State of Iowa

Iowa Administrative Code Supplement

Biweekly
July 2, 2008

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Published by the
STATE OF IOWA
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement pages to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement pages 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 pages may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(4); an effective date delay imposed by the ARRC pursuant to section 17A.4(5) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(6); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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CHAPTER 27
MILITARY SERVICE MEMBER HOME OWNERSHIP ASSISTANCE PROGRAM

265—27.1(16) Purpose. The purpose of the military service member home ownership assistance program is to help eligible members of the armed forces of the United States to purchase qualified homes in Iowa.

265—27.2(16) Definitions. As used in this chapter, unless the context otherwise requires:

"Closing agent" means the attorney, real estate firm, or closing company that is closing the cash sale qualifying purchase transaction and that prepares the cash sale settlement statement.

"Eligible service member" means a person purchasing his or her primary residence in the state of Iowa who, at the time of applying for a grant under the program, (1) is or was a member of the national guard, reserve, or regular component of the armed forces of the United States under Title 10 or Title 32 and has served at least 90 days of active duty service, other than training, beginning on or after September 11, 2001, and, if no longer in active service, was discharged in character other than dishonorable; (2) was honorably discharged due to injuries incurred while on active federal service beginning on or after September 11, 2001; or (3) is a surviving spouse of a service member who met the eligibility criteria of (1) or (2) above.

"Home ownership assistance" means the one-time grant of up to $5,000 per eligible service member that may be used toward down payment or closing costs, or both, in the purchase of a qualified home. This grant does not require repayment except pursuant to rule 265—27.4(16).

"Participating lender" means a lender approved for participation in the authority's first-time home buyer program that makes available the authority's first-time home buyer program to customers in the same manner as other mortgage loan programs. This requirement applies to branch and affiliate organizations that facilitate mortgage financing with the military grant. The authority may require participating lenders to provide evidence of proof of compliance, such as origination of the authority's first-time home buyer mortgages or mortgage rate sheets evidencing availability of the authority's mortgage program. The authority maintains a list of participating lenders on its Web site: www.iowafinanceauthority.gov.

"Program" or *"military grant"* means the military service member home ownership assistance program authorized by 2008 Iowa Acts, Senate File 2354.

"Qualified home" means a home that is located in the state of Iowa, that is purchased by an eligible service member as the eligible service member's primary residence on or after July 1, 2008, and that falls into one of the following categories:

1. Single-family residence, including "stick-built" homes, modular homes, or manufactured homes, provided the home is attached to a permanent foundation and is taxed as real estate;
2. Condominium;
3. Townhome;
4. A property containing two to four residential units, where one unit is to be occupied by the eligible service member as his or her primary residence.

The following categories of property shall not constitute a qualified home:

- Multifamily properties of five units or more;
- Commercial or nonresidential property;
- Farmland or other investment property;
- Recreational vehicles, mobile homes, or trailers not attached to a permanent foundation.

"Qualified mortgage " means a permanent mortgage loan made pursuant to the authority's first-time home buyer mortgage program for eligible first-time home buyers and targeted area home buyers or, in cases where the home buyer is not eligible for the authority's first-time home buyer mortgage program, any permanent mortgage loan with amortized payments and a maturity date of not less than five years made by a participating lender. First-time home buyer mortgage program information may be obtained on the authority's Web site at www.iowafinanceauthority.gov.

"Status documentation" means written documentation of the applicant's status with the armed forces of the United States, typically a copy of a valid DD Form 214, showing character of service other than dishonorable, most recent four months of leave and earnings statements, or other documentation satisfactory to the Iowa department of veterans affairs.

"Title guaranty certificate" means the certificate issued by the title guaranty division of the authority pursuant to Iowa Code section 16.92 to ensure marketable title to the lender or the homeowner or both. Information about title guaranty may be obtained at: www.iowafinanceauthority.gov.

265—27.3(16) Application procedure and determination of eligibility.

27.3(1) *Prior approval.* Whether the purchase of a qualified home is by mortgage financing or cash, a determination of the service member's eligibility by the Iowa department of veterans affairs and prior approval of the grant by the authority are required. A minimum of one week should be allowed for approval response from the authority.

27.3(2) *Financed home purchases.* In the case of the purchase of a qualified home that is to be financed, the eligible service member must apply for a grant under the program through a participating lender. The mortgage financing provided shall be the authority's first-time home buyer mortgage if the service member qualifies for it or another permanent mortgage if the service member does not qualify for the first-time home buyer mortgage. To apply for the military grant, the eligible service member shall provide a participating lender with status documentation, submit a bona fide purchase agreement with any addenda or attachments for a primary residence, complete a loan application on Form 1003, submit a copy of a government-issued photo identification card, and assist the participating lender in completing a grant application on a form approved by the authority which states the amount of the grant being requested. In the event the applicant is not eligible for the authority's first-time home buyer mortgage program, information evidencing ineligibility and acceptable documentation to the authority must accompany the application. The participating lender shall then transmit copies of the loan application, the status documentation, the purchase agreement, any necessary supporting documentation, the photo ID, and the grant application to the authority.

27.3(3) *Cash home purchases.* In the case of a cash purchase of a qualified home, the eligible service member shall provide directly to the authority status documentation, a completed grant application form obtained from the authority, and a bona fide purchase agreement with any addenda or attachments for a primary residence.

27.3(4) *Referral of status documentation to Iowa department of veterans affairs.* Upon receipt of the completed grant application, the authority shall submit the status documentation to the Iowa department of veterans affairs for verification that the applicant's duty status is consistent with the definition of "eligible service member." The Iowa department of veterans affairs shall be the final authority as to whether an applicant's duty status is consistent with the definition of "eligible service member."

27.3(5) *Notice of grant approval.* Upon confirmation of the applicant's service record by the Iowa department of veterans affairs, provided that the information submitted on the grant application form complies with the requirements of this chapter, the authority shall notify the participating lender, or eligible service member in the case of a cash purchase, that the grant application has been approved.

27.3(6) *Gaps in funding.* In cases where the grant funds are unavailable during the home purchase process, approved transactions shall be placed on a waiting list. When funds are again available and where the home purchase closed without the benefit of military grant funds being applied toward closing costs or down payment, the proceeds of the grant shall be paid (1) directly to the participating lender/servicing lender to be applied toward the qualified mortgage loan's principal balance or to replenish the eligible service member's contribution toward home purchase, or (2) if the qualified home was purchased pursuant to a cash purchase transaction, directly to the eligible service member. Additional documentation required shall include a statement executed by the applicant authorizing the grant to be applied to the principal balance.

265—27.4(16) Grant award. Grants awarded hereunder shall be up to $5,000 toward the purchase of a qualified home and may be used for down payment or for closing costs, or for both. Grant funds must be applied to the purchase of a qualified home and, in the case of mortgage financing, the mortgage must be a qualified mortgage. Any grant proceeds which are not used for down payment or closing costs toward the purchase of a qualified home which is financed by a mortgage must be returned to the authority.

27.4(1) *Grant reimbursement.* The participating lender or cash payment home buyer shall advance funds at closing in an amount equal to the amount of the grant on behalf of the eligible service member to be applied toward closing costs or the down payment. The participating lender or cash payment home buyer, as applicable, shall, within 30 days of closing, submit to the authority a copy of the executed HUD–1 Settlement Statement (or, if the transaction is a cash purchase, the eligible service member may use the settlement statement certified by a closing agent and the eligible service member), a copy of the deed conveying title to the qualified home, a copy of

a title guaranty certificate issued for the qualified home, and the military grant agreement and certification (form obtained from the authority) for reimbursement for the amount of the grant. In the event the mortgage financing is not made pursuant to the authority's first-time home buyer program, reimbursement documentation shall include a certified copy of the promissory note and mortgage.

27.4(2) *Grant restrictions and limitations.* All grants under the program are subject to funding availability. Grants will be awarded in the order in which completed grant applications are received. Grants awarded pursuant to the program are personal to their recipients and may not be assigned. Only one grant shall be awarded per home purchase. An eligible service member shall receive only one grant award under the program. While program funds are available, the grant award shall be valid for 60 days in the case of purchases of existing or completed property and 120 days in the case of purchases of property being constructed or renovated. A reasonable extension may be granted with evidence of a purchase loan in progress which has been delayed due to circumstances beyond the service member's control.

265—27.5(16) Income, purchase price and qualified mortgage. There are no income or purchase price limits under the program except that eligible service members purchasing with mortgage financing who are eligible for the authority's first-time home buyer program, whether a first-time home buyer or non-first-time home buyer purchasing in a targeted area, must use the authority's first-time home buyer mortgage program. Service members who are not eligible for the authority's first-time home buyer mortgage program and are not purchasing on a cash basis, must use other permanent mortgages made by the participating lender. Service members may also, if eligible, use other grant funds from the authority, grant fund assistance available through other public agencies or nonprofit organizations, the service member's employer, or any forgivable, "soft second" lien subsidy. Information about the authority's first-time home buyer program or how to contact a participating lender may be obtained on the authority's Web site at www.iowafinanceauthority.gov.

These rules are intended to implement Iowa Code Supplement section 16.5(1)*"r"* and 2008 Iowa Acts, Senate File 2354

[Filed emergency 7/14/06—published 8/2/06, effective 7/14/06]
[Filed emergency 4/3/07—published 4/25/07, effective 4/3/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

ELDER AFFAIRS DEPARTMENT[321]

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

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CHAPTER 4
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[Prior to 5/20/87, see Aging, Commission on the[20] Chs 3 to 5]

321—4.1(231) Definitions. Words and phrases as used in this chapter are as defined in 321 IAC 1 unless the context indicates otherwise. The following definition also applies to this chapter:

"Unit of general purpose local government" means a political subdivision of the state whose authority is general and not limited to only one function or combination of related functions.

321—4.2(231) State plan on aging.

4.2(1) *Authority.* The Iowa department of elder affairs is designated as the sole state unit on aging in Iowa for the development and implementation of a state plan on aging under Section 305 (42 U.S.C. 3025) of the Act.

4.2(2) *Duration and format.* The department shall develop a four-year state plan in compliance with the OAA and Iowa Code chapter 231, in order to receive grants under the Act. The state plan shall be developed in accordance with the format, content, time limits, transmittal forms, and procedures specified by the federal AOA. The state plan on aging shall also be in compliance with requirements for state plans under the Act, Section 307 and associated instructions, guidance or direction from the federal AOA.

4.2(3) *Process.*

a. The department shall hold at least one public hearing on the state plan.

b. The commission shall consider and approve the state plan or state plan amendment prior to submittal to the governor for approval and signature.

c. Each state plan or state plan amendment shall be signed by the governor and submitted to AOA to be considered for approval at least 45 calendar days before the effective date of the plan or the plan amendment.

321—4.3(231) Designation of PSA. Unless changed for reasons given in this chapter, the PSA boundaries shall remain the same as those existing on July 1, 1985.

4.3(1) *Criteria.* The PSA boundaries shall remain the same as those which existed on July 1, 1985, unless altered for cause under the provisions of this chapter. The commission may alter existing PSA boundaries only after giving consideration to and meeting all requirements under Section 305 (42 U.S.C. 3025) of the Act.

4.3(2) *PSA boundary alteration procedure.* Prior to submission of the multiyear state plan on aging, the commission shall notify the AOA of the intent to either maintain or alter existing PSA boundaries. If the intent is to alter PSA boundaries, the department shall utilize the following process:

a. Notice. The department shall advertise the intent to alter existing boundaries and the availability of applications to serve as a PSA in the affected area by sending notice to all AAA, units of local government, and known groups of elders in the affected PSA.

b. Publication. The department shall also publish a notice in at least one newspaper of statewide circulation and the official newspapers as designated for each county served by the affected PSA.

c. Time frame. The notice shall be published a minimum of 50 days in advance of the deadline for submitting applications.

d. Deadline. The notice shall state the precise deadline for requesting application packets as well as for submittal of completed applications.

4.3(3) *Application requests.* Interested applicants shall send a letter of intent to apply and a request for an application packet to the Department of Elder Affairs, Jessie Parker Building, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319. The letter and request must be received by the department prior to the deadline for requests as established in the notice provided pursuant to paragraph 4.3(2)*"d."*

4.3(4) *Application content.* The application shall contain information that indicates the applicant's ability to:

a. Meet the criteria established in the Act;

b. Conform to state law and rules promulgated by agencies having jurisdiction in the affected PSA.

4.3(5) *Public hearing.*

a. Within 60 days after notification of AOA as required in this rule, the department shall hold a minimum of one public hearing which shall be chaired by the director or the director's designee for the purpose of receiving presentations by the applicants and comments from the public.

b. The department shall designate a date, time and place for the hearing and shall publish notice at least two weeks in advance. If possible, the ICN network will be used to minimize travel for those wishing to participate, except applicants. Applicant presentations are to be given at the designated public hearing site in Des Moines.

c. The department may receive oral and written comments from interested persons prior to the hearing. These comments shall have the same weight and effect as those received at the hearing.

d. Presentations and comments at the hearing shall be time-limited and shall be prearranged with the department.

4.3(6) *Department review of applications and comments.*

a. The department shall review all applications and comments to determine the applicant most qualified to fulfill the PSA obligations for the affected area.

b. A synopsis of application and comment information shall be prepared for the commission. If requested, the commission may fully review all applications and comments.

c. Within 90 days after the public hearing, the department shall issue a proposed decision. The proposed decision shall be based on analysis of application content, public comments and criteria contained in Section 305 (42 U.S.C. 3025) of the Act.

4.3(7) *Commission action.* The commission shall act on the boundary alteration proposal or designation of a PSA at its next meeting after receipt of the department's proposed decision. As a part of the commission's action, the commission shall include an effective date which shall be at least 365 days after the final decision.

4.3(8) *Appeal.*

a. Any applicant for designation as an AAA whose application is denied may appeal the decision pursuant to 321 IAC 13.

b. At the conclusion of the appeal under 321 IAC 13, if the AAA wishes to continue the appeal process, the final decision may be appealed in writing to the assistant secretary of the AOA within 30 calendar days of receipt of the decision.

321—4.4(231) Designation of AAA. Unless changed for reasons given in this chapter, the AAA designations shall remain the same as those existing on July 1, 1985.

4.4(1) If, for any reason, there is need to change the AAA designation, the commission shall follow the procedures given in this chapter to designate an entity to be the AAA to serve each PSA as defined in this chapter.

4.4(2) The commission shall alter existing AAA designations only for the following reasons:

a. Withdrawal by the department of an existing AAA designation as outlined in this chapter;

b. Voluntary withdrawal by the existing AAA of its designation; or

c. A change in the designation of the PSA served by the AAA.

321—4.5(231) Types of entities that qualify as an AAA.

4.5(1) *Qualifications.* In order to qualify for designation as an AAA, an entity must have the authority and capacity to perform the functions of an AAA and handle the responsibilities outlined in 321 IAC 5, 6 and 7.

4.5(2) *Right of first refusal.* When the commission designates a new AAA, the commission shall give the right of first refusal to a unit of general purpose local government provided:

a. The unit can meet the requirements of this rule;

b. The unit's boundaries and the boundaries of the PSA are reasonably contiguous.

4.5(3) *First refusal process.* Should a unit of general purpose local government choose to exercise the right of first refusal, it shall make application for designation as an AAA as provided in this chapter.

4.5(4) *Order of preference.* When a unit of general purpose local government does not exercise the right of first refusal by making application, applicant preference categories shall be in the following order:

1. An established office on aging which is defined as a legally incorporated entity with employed staff whose single purpose is to administer programs for elders.
2. An agency whose single purpose is to administer programs for elders.
3. A multipurpose agency as defined in 321 IAC 4.6(231).
4. Any public or nonprofit private agency in a PSA which can engage in the planning and provision of a broad range of supportive or nutrition services within the PSA, except any regional or local agency of the state.

321—4.6(231) Multipurpose entity. An AAA may be a multipurpose entity with the authority and capacity to administer human services in the PSA.

4.6(1) A multipurpose entity shall delegate all its authority and responsibility under the Act to a single organizational unit within the entity unless it applies for and receives a waiver of this requirement from the

department under the authority and applicable procedures of 321 IAC 11 as a part of the application approval process.

4.6(2) A multipurpose entity previously designated as an AAA shall submit its waiver request as a part of its multiyear area plan.

4.6(3) When a multipurpose entity is designated as the AAA for a designated PSA, the governing body of that multipurpose entity shall be responsible to the department for the administration and operation of the aging programs under the multiyear area plan.

321—4.7(231) Request for waiver.

4.7(1) A request seeking waiver of the requirement to delegate all authority and responsibilities under the Act to a single organizational unit shall be submitted pursuant to the requirements of 321 IAC 11.6(17A,231,ExecOrd11) and shall:

a. Describe methods for carrying out the AAA's functions and responsibilities under the Act; and

b. Designate a component unit of the AAA to:

(1) Plan and develop policies and programs for elders in the multiyear area plan;

(2) Administer the area plan; and

(3) Provide a visible focal point for advocacy and coordination for the PSA.

4.7(2) The commission may approve a request for waiver if it is determined that the AAA can effectively carry out its functions and responsibilities under the Act without being a single organizational unit.

321—4.8(231) Applicant qualification and preference. The method for determining qualified applicants for AAA designation and for giving preference if there is more than one qualified applicant in any of the eligible applicant categories shall be in accordance with this chapter.

321—4.9(231) Procedure for designation of an AAA.

4.9(1) Notice. The department shall advertise the need for applications from qualified entities by sending notice to all units of local government, known groups of elders, and potential service providers in the affected PSA. In addition, the department shall publish a notice in the official newspapers as designated for each county served by the AAA a minimum of 45 days in advance of the deadline for submitting applications. The notice shall state the precise deadline for requesting application packets as well as for submittal of completed applications.

4.9(2) Requests. Interested applicants shall send a letter of intent to apply and a request for an application packet to the Department of Elder Affairs, Jessie Parker Building, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319. This material must be received by the department prior to the deadline for requests as established in the notice provided pursuant to 4.9(1).

4.9(3) Application content. The application shall contain, at a minimum, the following information for the entity:

a. Indications of organizational stability;

b. Administrative ability and staffing proposals;

c. Organizational structure;

d. Services offered;

e. Fiscal history and management capabilities;

f. Proposed methods for development of an advisory council whose members are representative of the PSA and the population served;

g. Ability to meet the requirements of this chapter and others governing administration, operation and reporting requirements for AAA;

4.9(4) Public hearing.

a. The department shall hold a minimum of one public hearing which shall be chaired by the director or the director's designee for the purpose of providing presentations by applicants and receiving comments from the public.

b. The department shall designate a date, time and place for the hearing and publish notice at least two weeks in advance. If possible, the ICN network will be used to minimize travel for those wishing to participate.

c. The department may receive oral and written comments from interested persons prior to the hearing. These comments shall have the same weight and effect as those received at the hearing.

d. Presentations and comments at the hearing shall be time-limited and shall be prearranged with the department.

4.9(5) Department review of applications and comments. Subsequent to the public hearing, the applications shall be sorted according to types of agencies and in the order of preference categories as given in 4.9(7). The department shall review all applications and comments based on the criteria established by this chapter to determine the applicants qualified for an on-site assessment. A synopsis of this information shall be prepared for the commission.

4.9(6) On-site assessment. The purpose of the assessment is to verify information provided in the application.

a. The department shall make arrangements for the assessment with the qualified applicant(s).

b. A written tool shall be used to conduct the assessment.

c. The department shall present to the commission a written report of the assessment and a written recommendation regarding the designation of an AAA.

d. The basis for the recommendation shall be the application review, the public comments, and the on-site assessment.

4.9(7) Preference process. Preference categories may be found in subrule 4.5(4).

a. The department shall determine whether any applicants in the first preference category are qualified.

b. If there is more than one qualified applicant in this category, the more qualified applicant will be determined by review, comparison and analysis of how well each applicant meets the criteria set forth in this chapter.

c. When the more qualified applicant has been determined, the designation may be offered to that applicant.

d. If for any reason that applicant is unable to accept the designation, the department may offer the designation to the second more qualified applicant in the first category, or the more qualified applicant in the second preference category shall be determined. A review, comparison and analysis shall be made between the applicant selected in the second preference category and the second-place applicant under the first category.

e. The designation may be offered to the more qualified of the two applicants. If for any reason that applicant is unable to accept the designation, the same process shall continue through the preference categories as given in this rule.

4.9(8) Commission action. When designating an AAA, the commission shall consider the following:

a. The synopsis of the application review as performed by the department;

b. The findings of the on-site assessment; and

c. Recommendations of the department.

4.9(9) The commission shall act on the designation of an AAA at its next meeting after receiving the department's recommendation.

321—4.10(231) Withdrawal of AAA designation. When an AAA cannot, or will not, fulfill its responsibilities as given in 321 IAC 5, the commission may withdraw the designation for reasons including but not limited to:

1. Substantial violation of grant terms and conditions or requirements and standards set forth in state law or rules promulgated by the department or other agencies having jurisdiction;
2. Inadequate performance of the responsibilities outlined in 321 IAC 5, 6, or 7 and any other chapters governing administration, operation and reporting for AAA;
3. The AAA's multiyear area plan is not approved by the commission;
4. Actual performance varies drastically from planned performance;
5. Financial instability;
6. Deficiency in implementation of programs;
7. Contractual or direct services to the elderly commenced more than two months after the approved project period;
8. Reporting of fiscal or performance data does not comply with written procedures issued by the department; or
9. The AAA has been unable or has refused to take timely remedial action to correct cited deficiencies within the given time frame established for correction.

321—4.11(231) Procedures for withdrawal of AAA designation.

4.11(1) When there is reason to withdraw AAA designation as outlined in this chapter, the department shall:

a. Notify the AAA in writing of the deficiency or deficiencies that form the reason for the withdrawal;

b. Provide technical assistance to determine the staffing, management, fiscal or other problems causing the reason for withdrawal;

c. Assist in developing a written action plan for correcting the reason within a given time frame;

d. Monitor the progress toward correcting the deficiency;

e. Report to the AAA in writing the findings of the monitoring; and

f. Determine appropriate commission action based on the progress as determined in monitoring progress reports, which may include:

(1) Placing the AAA in probationary status;

(2) Retrieval or withholding of funds;

(3) Suspension or withdrawal of AAA designation.

4.11(2) The department shall give written notice to the AAA of the right to appeal the designation withdrawal pursuant to 321 IAC 13.

321—4.12(231) Department action subsequent to withdrawal.

4.12(1) *Notification and plan.* When AAA designation has been withdrawn, the department shall:

a. Notify the AOA in writing of the designation withdrawal.

b. Implement a plan for continuity of services in the affected PSA.

c. Designate a new AAA in the PSA in accordance with this chapter.

4.12(2) *Continuity of services.* To ensure continuity of services in the affected PSA, the department may:

a. Perform the responsibilities of the AAA;

b. Assign the responsibilities of the AAA to another agency in the PSA; or

c. Submit a written request to the AOA for an extension of the current AAA designation for up to 180 days. The request must document the need for an extension to provide continuity of services in the affected PSA.

321—4.13(231) Technical assistance. The department may provide assistance as follows:

1. To an AAA that is unable to meet target dates, that has requested training, or in order to determine remedial action for performance deficiencies.

2. To any organization, agency, association or individual representing or serving the needs of elders.

321—4.14(231) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected thereby.

These rules are intended to implement Iowa Code chapter 231.

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

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

CHAPTER 6
AREA AGENCY ON AGING PLANNING AND ADMINISTRATION

[Prior to 5/20/87, see Aging, Commission on the[20] Ch 5]

321—6.1(231) Definitions. Words and phrases as used in this chapter are as defined in 321 IAC 1 unless the context indicates otherwise. The following definitions also apply to this chapter:

"Access" or *"access services"* means case management, transportation, outreach, information and assistance.

"Entrepreneurial activities" means the manufacturing, processing, selling, offering for sale, renting, leasing, delivering, dispensing, distributing or advertising of goods or services for profit; or a contract or agreement that an AAA will provide specific named service(s) for third-party payees.

"Priority services" means access, in-home and legal assistance services.

321—6.2(231) Area plan.

6.2(1) *Area plan.* Each AAA shall develop and administer an area plan.

6.2(2) *Duration and format of the area plan.*

a. The area plan shall be for the four-year period specified by the department, with annual updates.

b. Uniform area plan format. All AAA shall submit an area plan or plan amendment to the department in accordance with the uniform area plan format, other instructions issued by the department, this chapter, and the federal Act.

6.2(3) *Comprehensive and coordinated delivery system.* The multiyear area plan shall provide for the development of a comprehensive and coordinated service delivery system for all supportive and nutrition services needed by elders in the planning and service area to:

a. Facilitate access to and utilization of all existing services; and

b. Develop supportive and nutrition services effectively and efficiently to meet the needs of elders.

6.2(4) *Requirements.* An area plan shall provide for a comprehensive and coordinated service delivery system as defined in:

a. The federal Act;

b. Older Americans Act Title III Regulations; Code of Federal Regulations, Title 45, Volume 4, Part 1200 (45 CFR 1321);

c. This chapter;

d. IAPI issued by the department.

6.2(5) *Plan content.* The area plan shall, at a minimum, contain the following information:

a. Assurance that the AAA agrees to abide by the requirements of the federal Act and all other applicable laws and rules; and

b. Objectives and budget for each year of the designated four-year period and methods to obtain those objectives; and

c. Client estimates. Area agencies shall estimate the number of elders with the characteristics identified in Form 3 A 1 of an IAPI.

6.2(6) *Area plan amendments and revisions.*

a. Amendments. The AAA shall amend the area plan and submit it to the commission for approval when:

(1) A new or amended state or federal statute, rule or regulation requires new information or conflicts with any existing plan provisions;

(2) A United States Supreme Court decision changes the interpretation of a statute or rule;

(3) Local law, organization, policy or agency operations change and are no longer accurately reflected in the area plan;

(4) The department requires amendments;

(5) The grantee proposes to change the designation of the single organizational unit or component unit responsible for programs under the federal Act or state law; or

(6) The area agency proposes to add or delete a service category.

b. Revision. The AAA may be required to revise the plan and submit it to the department for approval if:

(1) A department funding source to the area agency changes; or

(2) A program requirement changes.

6.2(7) *Procedures for area plans, plan amendments and revisions.*

a. Public hearing(s). The AAA shall hold at least one public hearing on the area plan and all plan amendments as required in this chapter. Priority services shall appear as a distinct agenda item for any hearing.

(1) The public hearing(s) shall be held prior to submission of the area plan or amendment(s) at a time which permits elders, public officials, and other interested parties reasonable opportunity to participate. The hearing(s) shall be held at a barrier-free, fully accessible location.

(2) The AAA shall advertise the hearing by sending notice to all known groups of elders, PSA public officials, and other interested parties. The AAA shall also publish a notice in the official newspapers as designated for each county served by the PSA. The notice shall include the time, date, and location of the public hearing.

b. Review and comment by the advisory council.

(1) The AAA shall submit the area plan, amendments and revisions for review and comment to the AAA advisory council.

(2) The official representative of the AAA shall sign the plan, amendment or revision to signify that the AAA has completed all of the requirements of this chapter. The AAA shall then submit the area plan, amendment or revision to the department for review.

6.2(8) *Commission review.* Plans and plan amendments may be approved by the commission after they have been processed in accordance with the process given in this chapter. Revisions may be approved by the department after they have been processed in accordance with the process given in this chapter.

6.2(9) *Appeals.* Any person may appeal a denial of approval of an area plan, plan amendment or revision as provided in 321 IAC 4.

6.2(10) *Area profile.* Each AAA shall submit to the department a profile in accordance with the time frame and procedures as issued in department IAPI. The profile shall contain, but not be limited to, the following AAA information:

a. Affirmative action plan;
b. Table of organizational structure;
c. Inventory of nutrition sites and senior centers;
d. Listing of the area agency's designated community focal points; and
e. Listing of the officers of the AAA board of directors.

321—6.3(231) Area agency administration.

6.3(1) *Full-time director.* The AAA shall employ a qualified full-time director and may employ other staff as necessary to manage and monitor the area plan.

6.3(2) *Director's responsibility.* It is the responsibility of the AAA director to:

a. Ensure that all AAA duties as outlined in the federal Act, state law, this chapter and other rules promulgated by any agency having jurisdiction are performed;
b. Develop the area plan;
c. Implement organizational operations;
d. Budget for services and operations;
e. Coordinate implementation of services; and
f. Monitor and evaluate services.

6.3(3) *Discrimination.* The AAA shall offer equal opportunities for employment or promotion to all employees and to applicants who meet the qualifications of the open position. Discrimination against any person because of gender, race, national origin, age, political affiliation, creed, color, religion, physical or mental disability, or other nonmerit factors is prohibited during any aspect of personnel administration and during employment.

6.3(4) *Affirmative action plans.* Each AAA shall develop an employment affirmative action plan which shall be submitted as part of the profile required in this chapter. All affirmative action plans shall comply with the requirements as given in IAPI.

6.3(5) *Training and development requirements.* Each AAA shall have a plan and procedures that will support a broad program of staff development activities to ensure training of volunteers, paid personnel and providers of services to Iowa's elder population.

321—6.4(231) Confidentiality and disclosure of AAA information.

6.4(1) *Confidentiality.* AAA shall implement procedures to ensure that no information in possession of an AAA, or an entity providing services under programs funded by the department, is disclosed in a form identifiable with an individual without that individual's informed consent regardless of the source of the information.

6.4(2) *Public accessibility to manuals, guidelines, and standards.* Copies of all manuals, guidelines, and standards referred to by these rules shall be maintained by the AAA and available for public inspection.

321—6.5(231) AAA contact information. Information on how to contact the appropriate AAA office may be obtained by sending a request to the Department of Elder Affairs, Jessie Parker Building, 510 East 12th Street, Suite 2, Des Moines, Iowa 50319; or by telephone at (515)725-3333; or by visiting the department's Web site www.state.ia.us/elderaffairs/.

321—6.6(231) Duties of AAA.

6.6(1) General. Each AAA shall fulfill the AAA duties specified in the federal Act, Iowa Code section 231.33 and this chapter. AAA shall:

a. Carry out functions related to advocacy, planning, coordination, interagency linkages, information sharing, brokering, monitoring and evaluation designed to lead to and maintain a comprehensive and coordinated community-based system. This system shall serve the PSA so that elders may lead independent, meaningful and dignified lives in their own homes and communities for as long as possible;

b. Strive to offer a range of services which are readily accessible to all elders by utilizing public, private and voluntary entities and personal resources of the client;

c. Encourage collaborative decision making among public, private, voluntary, religious and fraternal organizations, as well as elders;

d. Assist in determining and providing special assistance or resources to the most vulnerable elders who are in danger of losing their independence; and

e. Perform all functions as delineated in the area plan.

6.6(2) Additional duties include:

a. Attempt to involve the private bar and legal services corporation in the PSA in legal assistance activities;

b. Submit all reports in accordance with IAPI of the department;

c. Coordinate AAA activities with mental health services provided by community health centers and other nonprofit private or public organizations;

d. Compile and summarize information on institutions of higher education in the PSA which offer courses of study to elders at a no- or reduced-tuition rate and disseminate the information to elders at their gathering places;

e. Seek out elders who may be eligible to receive Supplemental Security Income benefits under Title XVI of the Social Security Act, medical assistance under Titles XVIII and XIX of the Social Security Act, and benefits under the Food Stamp Act of 1977. The AAA shall provide information on the requirements for eligibility to receive these benefits and assist in applying for appropriate assistance and benefits;

f. Coordinate planning by individuals, agencies and organizations interested in the prevention of abuse, neglect and exploitation of elders and assist in implementation of educational and awareness activities, in coordination with the long-term care resident's advocate program;

g. Coordinate planning with other agencies and organizations to provide health promotion activities for elders.

321—6.7(231) AAA board of directors.

6.7(1) Each designated AAA shall establish a board of directors in accordance with its individual articles of incorporation and bylaws.

6.7(2) The AAA board membership shall be representative of the geographic planning and service area.

6.7(3) Each AAA board of directors shall have board nominating and election procedures specified in its bylaws.

6.7(4) Each AAA shall specify in its bylaws the scope, function and responsibilities of the board, board committees and individual board members.

6.7(5) Each AAA shall provide an orientation process for newly elected board members that includes, at a minimum, the scope, function and responsibilities of the AAA and the responsibilities of the board, board committees and individual board members.

6.7(6) The department shall provide a minimum of four hours of training annually to AAA board members.

6.7(7) The AAA board of directors shall comply with Iowa Code chapter 504, "Revised Iowa Nonprofit Corporation Act."

321—6.8(231) AAA advisory council.

6.8(1) *Member requirements.* The AAA shall establish an advisory council composed of members, at least one-half of whom are aged 60 and older, which shall include:

a. Recipients of services under the Act, including minority elders and elders residing in rural areas;

b. Representatives of elders;

c. Current local elected officials;

d. The general public;

e. Representatives of health care provider organizations, including providers of veterans' health care, if appropriate;

f. Representatives of supportive and nutrition service providers; and

g. Persons with leadership experience in private and volunteer sectors.

6.8(2) *Duties.* It shall be the specific responsibility of the advisory council to advise the AAA and:

a. Advocate for elders in the PSA by keeping informed of all activities and proposals concerning the elders;

b. Review and make recommendations on the content, formulation, administration and priorities of the area plan and participate in public hearings on the area plan;

c. Serve as an information link between the AAA and providers of services to elders in the PSA;

d. Review and comment on community policies, programs and actions which affect elders;

e. Assist in generating local support for development of programs for elders in the area.

6.8(3) *Frequency of meetings.* The AAA advisory council shall meet at least quarterly.

6.8(4) *Staff support.* The AAA shall provide staff and assistance to the AAA advisory council.

6.8(5) *Bylaws.* The AAA advisory council bylaws shall contain at least the basic bylaws: name, purpose, members, officers, meetings, committees, parliamentary authority and procedure for amendment of bylaws. The bylaw on membership shall include, but is not limited to, the number of, selection process and length of terms for members.

321—6.9(231) Emergency situations.

6.9(1) Prior to and after a natural disaster or other safety-threatening situation, each AAA shall plan and coordinate with other public and private entities for safe and timely continuity of service and the restoration of normal living conditions for elders. This shall include:

a. Alerting elders of the impending danger;

b. Assessing the needs of elders after the event occurs; and

c. Ensuring that identified needs are met through collaboration with other agencies.

6.9(2) To further this purpose, each AAA shall:

a. Include in the procedures manual established as required in this chapter procedures to respond to emergency or disaster situations;

b. Include in the development and training plan methods of training for staff, contractors, and other interested parties in response to emergency or disaster situations; and

c. Include in subgrants or contracts provisions for responding to emergency or disaster situations including, but not limited to, shifting funds from one activity to another or from one contractor to another.

6.9(3) Services. As a part of emergency response, the AAA may plan, coordinate and provide services funded under other programs consistent with responsibilities of an AAA.

321—6.10(231) AAA procedures manual. A procedures manual shall be developed and kept current by the AAA. The manual shall, at a minimum, establish procedures to be followed in:

6.10(1) Establishing and maintaining information and assistance availability to ensure that elders within the PSA will have convenient access to services;

6.10(2) Conducting periodic evaluations, which may include participant satisfaction surveys of activities carried out under the area plan;

6.10(3) Furnishing appropriate technical assistance to providers of supportive services, nutrition services, or multipurpose senior centers;

6.10(4) Establishment of a request for proposal process that includes methods of selection of providers and methods for award of grants or contracts under the area plan, including stipulations that all subcontractors or subgrantees comply with all applicable local, state and federal laws, rules or regulations, and, if applicable, all requirements for nonprofit entities;

6.10(5) Resolving complaints by any aggrieved party directly affected by an action or omission of the AAA. AAA appeal procedures shall be in compliance with the relevant federal and state statutes, regulations and rules and shall contain at least the following procedures and time frames for complaint resolution:

a. Acknowledgment of the complaint;

b. Process for attempting to informally resolve the complaint;

c. Time frame for sending a hearing notice;

d. Process for holding a hearing;

e. Notification of the outcome of the hearing;

f. Appeal to the next higher authority;

6.10(6) Ensuring confidentiality, so that no information about or obtained from an elder is disclosed in a form that identifies the person without the person's informed consent;

6.10(7) The assessment and monitoring methods for programs and subcontracts funded by the AAA. This shall include documentation of quarterly monitoring of performance and on-site assessment and report at least annually;

6.10(8) Response to emergency or disaster situations;

6.10(9) Development of methods by which priority for delivery of services is determined;

6.10(10) Obtaining comments or suggestions from recipients about services provided by the AAA;

6.10(11) Determination of an individual's eligibility for home-delivered nutrition services, including specific criteria established by the AAA for:

a. Initial and subsequent six-month assessments of the individual's eligibility for home-delivered meals;

b. Determination of the number of days per week the individual has a need for home-delivered meals;

c. Determination of the individual's need for other home-delivered nutrition services;

6.10(12) Assurance that any facility housing a service will fully comply with all current federal, state or local health, fire, safety, sanitation, accessibility and licensure requirements;

6.10(13) Methods of monitoring service providers to ensure their performance is in accordance with terms, conditions and specifications for funding, including length of funding period, and the use of project income and methods of providing service;

6.10(14) If appropriate, offering a meal to individuals providing volunteer services during meal times on the same basis as meals are offered to eligible individuals;

6.10(15) Offering a meal to nonelderly individuals with disabilities who reside at home with and accompany eligible elders to a meal site;

6.10(16) Offering home-delivered meals to nonelderly individuals with disabilities when their elderly caregiver is eligible for a home-delivered meal;

6.10(17) Increasing public education and awareness in the prevention of abuse, neglect and exploitation of elders;

6.10(18) Identifying the public and private nonprofit entities involved in the prevention, identification, and treatment of abuse, neglect, and exploitation of elders and determining methods to respond to the needs of elders at risk; and

6.10(19) Offering health promotion activities and information to eligible individuals.

321—6.11(231) Contracts and subgrants.

6.11(1) A contract or agreement between an AAA and a provider of a specific service in the PSA shall not restrict the AAA from contracting with other provider(s) of similar services.

6.11(2) Contract file. AAA shall maintain a file of all current contracts with service-providing agencies or organizations. These files shall be made available for monitoring and assessment by the department.

6.11(3) Contracts with for-profit organizations. An AAA must request prior approval from the department of any proposed service contracts with for-profit organizations under an area plan.

a. A separate approval request, using the request form provided by the department, shall be filed for each contract between the AAA and a provider for a service that is proposed to be delivered by a for-profit organization.

(1) The request for approval shall be submitted to the department at least 30 days prior to the signing of the contract.

(2) All applicants to provide services for which the contract is proposed shall be listed on the request form.

b. The department may approve the contracts only if the AAA demonstrates that the for-profit organization can provide services that are consistent with the goals of the AAA as stated in the area plan.

c. Services shall mean the services described in the uniform definitions of services contained in IAPI issued by the department.

321—6.12(231) Direct service.

6.12(1) An AAA must submit a request to provide direct service as part of the area plan. The request may be approved by the department based on documentation of the criteria given in subrule 6.12(3). The following services may be furnished directly by the AAA and are exempt from the requirements in subrule 6.12(3):

a. Information and assistance;
b. Outreach;
c. Case management;
d. Advocacy representation;
e. Public education;
f. Employment services;
g. Mental health outreach;
h. Coordination of efforts concerning the prevention of elder abuse.

6.12(2) Public hearing. Prior to the submission of the area plan, the AAA shall hold a public hearing to obtain comments regarding direct service(s) planned by the AAA. This hearing may be held separately or as a part of the hearing for the area plan.

a. Notice of the hearing shall be published at least 30 days prior to the hearing and shall specify the direct service(s) which the AAA plans to provide.

b. The AAA shall prepare and submit to the department a written record of the public hearing.

6.12(3) Criteria. The commission may approve an AAA request to provide direct service.

a. Approval will be based upon documentation of the following as submitted by the AAA:

(1) Direct provision of service is necessary to ensure an adequate supply of the service, and no potential provider was identified during the public hearing process; or

(2) The proposed service will be of comparable quality in the view of the AAA advisory council, and will meet or exceed service standards developed by the AAA; and

(3) The AAA can provide a service of equal quality at lower cost than another provider.

b. The department may consider other factors including:

(1) The demonstrated capacity of the AAA to deliver services consistently and reliably;
(2) The economic impact of transition from a contract provider to the AAA;
(3) Consideration of any possible disruption of service;
(4) Input from the AAA advisory council; and
(5) Comments from the public.

6.12(4) Conditional approval. If the criteria for approval of a request to provide direct services are not met, a condition may be placed on the area plan approval.

321—6.13(231) Noncompliance. When an AAA's performance in any service does not meet the standards set by the department, the department shall initiate the procedure outlined in 321 IAC 4.

321—6.14(231) Priority service expenditures.

6.14(1) An AAA shall spend a specified percentage of its supportive services allotment on priority services, excluding the amount of federal funds used for administration. Funds shall be spent in each of the following priority service categories in at least the minimum percentage most recently determined by the commission:

a. Access services as defined in this chapter – 10 percent;
b. In-home services – 5 percent; and
c. Legal assistance – 3 percent.

6.14(2) Public hearing. The hearing on the area plan shall include the priority services and priority services requirement as a distinct agenda item with a specific time set for the beginning of that portion of the hearing.

a. Discussion at the hearing shall include the level of priority services being provided by all other agencies.
b. Record of the public hearing. The AAA shall prepare a written record of the hearing.

321—6.15(231) Waivers of priority service expenditures.

6.15(1) An AAA shall request a waiver from the priority service expenditures in 321—subrule 5.3(3) if it does not propose sufficient funding to allow elders to have convenient access to a service. The waiver request shall be submitted with the plan or plan amendment pursuant to applicable procedures under 321 IAC 11.

6.15(2) The commission, in approving an area plan or a plan amendment, may, upon recommendation of the director, waive the requirement of rule 6.14(231) for any category of service for which the AAA demonstrates the following:

a. That the services being furnished by other providers meet the needs of elders in the PSA for that category of service; or

b. That the AAA has made every reasonable effort to meet the need for a specific category of service.

321—6.16(231) Requirements for service providers.

6.16(1) *Contributions.* The AAA shall consult with the relevant service providers and elders in the PSA to determine the best method for accepting voluntary contributions. As established by contract with the AAA, each service provider, including an AAA providing direct service, shall:

a. Provide each elder with a voluntary opportunity to contribute to the cost of the service by displaying a suggested contribution schedule that takes into consideration income ranges of eligible individuals in local communities;

b. Clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;

c. Protect the privacy and confidentiality of each elder with respect to the person's contributions;

d. Utilize appropriate procedures to safeguard and account for all contributions against loss, mishandling or theft by obtaining bonding for all employees and volunteers in accordance with instructions issued by the department in an IAPI;

e. Use all contributions to expand the service for which such contribution is given. Nutrition service providers shall use all contributions to increase the number of meals served.

6.16(2) *Failure to contribute.* A provider that receives department funds may not deny any elder a service because the person will not or cannot contribute to the cost.

6.16(3) *Obtain views of elders.* Each provider shall utilize procedures determined by the AAA for obtaining the views of participants about the services they receive. A report of procedures utilized and findings shall be issued by the AAA within six months of the signing of the contract.

6.16(4) *Seek other sources of funding.* Prior to requesting Title III funding, service providers shall demonstrate efforts to seek funds from other federal, state, and local sources.

6.16(5) *Compliance by service providers.* The AAA shall incorporate in its contract with each service provider an assurance that funds are used in compliance with federal guidelines.

321—6.17(231) Entrepreneurial activities of AAA. An AAA considering entrepreneurial activities must carefully examine the activity to ensure compatibility with its designation as an AAA. The following shall apply to all AAA, unless otherwise prohibited by statute, rule or order:

6.17(1) *Demonstrated need—use of funds.* AAA may engage in entrepreneurial activities if the activity is in response to a demonstrated need and the funds raised by such activities are used for one of the following purposes:

a. To further extend services and opportunities for elders; or

b. To fund new services and opportunities for elders provided that these services or opportunities are compatible with the AAA functions and goals.

6.17(2) *Restrictions.* An AAA shall not use funds received from the department in connection with entrepreneurial activities.

a. Entrepreneurial activities shall not be undertaken until they have been reviewed by the advisory council and approved by the AAA governing board.

b. An AAA that engages in entrepreneurial activities shall not create the impression that the activity is being carried on under governmental authority.

c. Funds received as a result of entrepreneurial activities shall be monitored and accounted for according to generally accepted accounting and auditing practices commensurate with the activities.

d. Entrepreneurial activities shall be pursued only if the duties and responsibilities required of AAA in this chapter are consistently provided by the AAA in a capable manner.

e. Entrepreneurial activities shall benefit all eligible persons in the PSA, particularly elders in the greatest economic and social need and low-income minority persons.

6.17(3) *Department review.*

a. An AAA shall inform the department in writing not less than 160 calendar days prior to the initiation of an entrepreneurial activity of an ongoing nature. The notification shall describe the proposed activity, proposed source of funds, and the needs being addressed.

b. The department shall respond in writing within 30 calendar days to acknowledge receipt of the information, request clarification, or request a delay in implementation. For informational purposes, the department shall provide a copy of the response to the commission.

c. An AAA that receives no response from the department within 30 days may assume that no additional submission of information is required.

d. If unresolved issues remain after 60 calendar days of receipt of the information, the commission will be informed of those issues at the next commission meeting.

6.17(4) *Commission or department action.* An AAA contracting for entrepreneurial activities shall:

a. Provide the contract to the department for review prior to signing; and

b. Include the activities in the area plan, plan amendments or revisions; and

c. Require a minimum payment from the contractor to fully cover all costs of the activity, including overhead and administrative costs, to eliminate the possibility of use of Title III funds.

6.17(5) *Community interest.*

a. Entrepreneurial activities pursued by an AAA and groups or organizations funded by an AAA shall not have, nor present appearance of, conflict of interest.

b. An AAA shall work cooperatively with community leaders, groups and organizations in order to participate in entrepreneurial activities.

321—6.18(231) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected thereby.

These rules are intended to implement Iowa Code chapter 231.

[Filed 5/20/82, Notice 3/17/82—published 6/9/82, effective 7/14/82]
[Filed 5/1/87, Notice 2/25/87—published 5/20/87, effective 6/24/87][1]
[Filed emergency 8/20/87—published 9/9/87, effective 9/2/87]
[Filed 4/25/89, Notice 7/27/88—published 5/17/89, effective 6/21/89]
[Filed 4/26/90, Notice 2/21/90—published 5/16/90, effective 6/30/90]
[Filed 2/1/91, Notice 11/28/90—published 2/20/91, effective 3/27/91]
[Filed without Notice 1/13/92—published 2/5/92, effective 3/11/92]
[Filed 6/26/92, Notice 4/1/92—published 7/22/92, effective 8/26/92]
[Filed 11/5/93, Notice 9/15/93—published 11/24/93, effective 12/29/93]
[Filed 2/21/06, Notice 11/23/05—published 3/15/06, effective 5/1/06]
[Filed 8/9/06, Notice 6/7/06—published 8/30/06, effective 10/4/06]
[Filed 6/12/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]

[1] Effective date of Ch 6 delayed 70 days by the Administrative Rules Review Committee.

CHAPTER 9
RESIDENT ADVOCATE COMMITTEES

321—9.1(231) Definitions. Words and phrases used in this chapter are as defined in 321 IAC 1 unless the context indicates otherwise. The following definitions also apply to this chapter.

"Committee" means a resident advocate committee as provided in Iowa Code sections 135C.25 and 231.44.

"Relatives" means any one of the following: father, mother, son, daughter, brother, sister, aunt, uncle, first cousin, nephew, niece, wife, husband, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepbrother, stepchild, stepsister, half sister, half brother, grandparent or grandchild.

"Resident's advocate/ombudsman" means the state long-term care resident's advocate as provided in Iowa Code section 231.42.

321—9.2(231) Resident advocate committees established.

9.2(1) *Committee for each licensed facility.* Pursuant to Iowa Code sections 135C.25 and 231.41 through 231.44, a resident advocate committee shall be established for each licensed health care facility as defined in Iowa Code section 135C.1 and shall operate within the scope of the Code of Iowa and this chapter.

9.2(2) *Committee membership.* The committee shall consist of a number of members sufficient to meet the needs of the residents. The minimum number of members in facilities licensed to serve fewer than 15 residents is one; the minimum number of members in facilities licensed to serve 15 or more residents is two.

9.2(3) *Committee member residence.* Committee members shall reside within the service area of the facility.

321—9.3(231) Application for committee membership. An interested individual may apply to the department for membership. Individuals, AAAs and other organizations are encouraged to recommend potential volunteers for committee membership to the department pursuant to Iowa Code section 135C.25.

9.3(1) *Application forms.* Application forms may be obtained from the department at the address listed in 321 IAC 2.3(2), from the department Web site or from organizations designated by the department.

9.3(2) *Submission of forms.* Each applicant shall complete and submit an application for membership to the department at the address in 321 IAC 2.3(2).

9.3(3) *Membership restriction.* Applications shall be approved only when written consent is submitted by both the resident's advocate/ombudsman and the administrator of the facility if an applicant:

a. Has an ownership interest in the facility; or

b. Is employed by the facility or a competing facility; or

c. Has been employed by the facility within the past three years; or

d. Is related to an employee, board member, or licensee of the facility; or

e. Is a public employee involved with the sponsoring or placement of residents in the facility; or

f. Is an administrator of a long-term care facility; or

g. Is a professional consultant to the facility.

9.3(4) *Waiver of membership restriction.* When the resident's advocate/ombudsman or the facility administrator does not approve an application, the membership restriction for relatives in paragraph 9.3(3)*"d"* may be waived by the director if sufficient evidence can be presented showing that the membership will not cause a conflict of interest.

321—9.4(231) Appointment to resident advocate committees.

9.4(1) *Notification.* Acceptance of an application shall be confirmed by letter within 15 business days of receipt of the application by the director or designee. Each facility shall be notified of final committee appointments.

9.4(2) *Orientation.* All applicants shall complete the required orientation prior to final appointment and the beginning of volunteer duties.

321—9.5(231) Objection to and termination of appointments to resident advocate committees.

9.5(1) *Filing an objection.* A facility administrator who objects to a particular member's participation on the committee for that facility may file a written objection with the director. The objection shall be investigated as a confidential complaint, and all parties shall be notified of the director's decision.

9.5(2) *Reasons for termination.* A committee member's appointment may be terminated by the director for any of the following reasons:

a. Falsification of information on the application form;

b. Acting as a member prior to appointment;

c. Attending less than one-half of the meetings convened each year by the resident advocate committee chairperson;

d. Conviction of an illegal activity;

e. Breaching confidentiality;

f. Failure to attend approved training for two consecutive years; and

g. Actions which are found by the director to violate these rules or the intent of the state long-term care ombudsman program.

9.5(3) *Notification of termination.* The director shall notify, in writing, the committee chairperson and the facility of the termination of a resident advocate committee member's appointment.

321—9.6(231) Request for reconsideration of appointment or termination of appointment.

9.6(1) *Request.* A request for reconsideration concerning appointment, nonappointment or termination shall be made in writing to the department within 30 days of the written notice of the director's action.

9.6(2) *Decision.* The director shall consider the request within 30 days of receipt and notify all parties of the decision.

321—9.7(231) Resident advocate committee structure and procedures.

9.7(1) *Structure.* Every committee shall have a chairperson and secretary selected by the membership. The chairperson shall coordinate the activities of the committee. The secretary shall record minutes of each meeting and prepare reports as necessary. The chairperson and secretary shall be elected to a term of not more than three years.

9.7(2) *Resident visits.* Committee members shall spend at least three hours each month making visits to observe residents at different times of the day and in differing circumstances and shall document the visits.

9.7(3) *Meetings.* The committee shall meet at least quarterly and on other occasions as required to accomplish its responsibilities. The chairperson shall notify all members of the time and place of each meeting at least two weeks in advance.

a. The administrator and staff of the facility shall not attend committee meetings except upon request of the committee.

b. Confidential information shall not be discussed during meetings if anyone other than committee members is present.

c. Reports of each visit shall be discussed with the committee as appropriate.

d. The secretary shall complete the meeting minutes summary form designated by the department. Copies of the form shall be submitted to the facility administrator and to the office of the resident's advocate/ombudsman within ten business days following the meeting.

e. The forms shall be retained by the facility for a period of at least two years and shall be available to the department of inspections and appeals and the department of elder affairs upon request.

321—9.8(231) Duties of the committee. Committee members shall, at a minimum, participate in one training session approved by the department each calendar year. Committee members shall represent and advocate for the rights of residents of the facility. As a part of this advocacy, committee members shall investigate complaints and grievances according to the procedures established in rule 321—9.11(231).

321—9.9(231) Committee access and assistance.

9.9(1) *Access.* The committee shall have access to facilities, persons and records as provided in the Act, Iowa Code section 231.42 and this chapter.

9.9(2) *Assistance to the committee.* The committee may request information, advice and counsel from the facility administrator or the department. When, in the performance of duties, a committee member contacts anyone on behalf of residents, the committee member shall clearly identify himself or herself and shall clearly state the purpose of and justification for such contact.

321—9.10(231) Confidentiality.

9.10(1) *Access restriction.* Resident advocate committee members shall not have access to the following records unless access is granted by the resident or the resident's responsible party, such as a guardian or conservator, and the resident's advocate/ombudsman:

a. Medical, financial or personal records of residents; or

b. Records of the social services department of the facility.

9.10(2) *Nondisclosure of information.* The committee shall not disclose information concerning residents or the operation of a facility in a manner that will identify individuals or the facility, except to the state long-term care ombudsman program or as requested by the department of inspections and appeals in the investigation of a facility.

321—9.11(231) Committee response to complaints and grievances. Throughout the investigation of all complaints and grievances, the committee shall maintain objectivity and act as advocates for residents without being adversaries of the facility.

9.11(1) In all investigations, the committee shall:

a. Maintain the dignity and privacy of residents, as shall all other persons involved in a complaint or grievance investigation.

b. Using the procedures appropriate to the source of the complaint, receive and investigate complaints or grievances from an individual or the department regarding the rights and welfare of residents.

c. Seek to resolve the complaint or grievance and, if feasible, prevent unnecessary regulatory action against a facility. However, the committee shall not prevent or dissuade regulatory action when necessary to protect or achieve the rights of residents.

d. Solicit input from the complainant and the resident regarding the choices for action to be pursued by the committee.

9.11(2) Action upon receipt of a complaint or grievance. The committee may contact the facility administrator to discuss the allegations only if doing so does not violate confidentiality.

a. Information that identifies the complainant or resident shall be confidential unless the complainant or resident has given permission to the committee to disclose this information. This permission shall be documented in a committee member's notes.

b. The investigating committee member shall make at least one unannounced visit to the facility.

c. The committee shall, to the extent possible, ascertain the facts of the situation through personal observation of conditions and activities in the facility and by talking with all persons who may have knowledge regarding the matter under investigation.

d. If a resolution cannot be reached, the committee may contact the resident's advocate/ombudsman for follow-up action as appropriate.

e. Committee members shall keep the complainant informed of progress in the investigation.

321—9.12(231) Complaints referred from the department of inspections and appeals. The following procedures shall apply to complaints received or initiated by the department of inspections and appeals and referred to the department of elder affairs for investigation by a resident advocate committee.

9.12(1) *Confidentiality.* Information that may identify the complainant or resident shall be confidential.

9.12(2) *Notification.* Depending on the circumstances in each instance, the state long-term care ombudsman program shall provide adequate verbal information within three days to a member of the appropriate resident advocate committee so that an investigation may proceed. Written notification shall be provided within seven days.

9.12(3) *Investigation.* Investigation of the complaint or grievance shall be conducted in accordance with rule 321—9.11(231).

321—9.13(231) Accountability measures.

9.13(1) The committee shall use a standardized form developed by the department, to be completed by the secretary, to specify issues and concerns identified by residents, the facility's response, and whether the matter has been resolved.

9.13(2) An issue or concern shall be designated as resolved when the committee and the facility agree it has been resolved. If there are unresolved issues and the facility disagrees with the committee's

determination regarding the resolution of an issue or concern, the facility may request a review by the resident's advocate/ombudsman by submitting a written request within 20 calendar days of receipt of the form described in this rule.

9.13(3) Upon receipt of a request for review, the resident's advocate/ombudsman shall contact the facility administrator and the chairperson of the resident advocate committee to discuss the request. The resident's advocate/ombudsman has the discretion to:

a. Uphold the committee's determination,

b. Designate the issue or concern as resolved, or

c. Redefine the issue or concern as a means to negotiate a compromise.

9.13(4) The decision of the resident's advocate/ombudsman shall be made within 20 calendar days of the receipt of a request for review. Additional time may be allotted by agreement of the resident advocate committee and the facility administrator.

9.13(5) An aggrieved party has 30 calendar days from the receipt of written notice of the decision of the resident's advocate/ombudsman to request a hearing pursuant to 321 IAC 13.

9.13(6) All appeals and judicial review shall be conducted pursuant to 321 IAC 13.

321—9.14(231) Reporting statistics. The office of the resident's advocate/ombudsman shall record the number of issues and concerns listed on the forms submitted by the committees and the number resolved. Each year, the office of the resident's advocate/ombudsman shall calculate the percentage of issues and concerns that are resolved, based on the total number of issues and concerns identified between January 1 and December 31 of the preceding year. Prior to May 1 of each year, the office of the resident's advocate/ombudsman shall report the resolution rate of each facility to the department of human services.

321—9.15(231) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected.

These rules are intended to implement Iowa Code section 231.44.

[Filed 5/1/87, Notice 2/25/87—published 5/20/87, effective 6/24/87][1]
[Filed emergency 8/20/87—published 9/9/87, effective 9/2/87]
[Filed 7/8/88, Notice 1/27/88—published 7/27/88, effective 8/31/88]
[Filed 3/30/00, Notice 2/23/00—published 4/19/00, effective 5/24/00]
[Filed 6/21/02, Notice 3/6/02—published 7/10/02, effective 8/14/02]
[Filed 1/16/04, Notice 10/29/03—published 2/4/04, effective 3/10/04]
[Filed 6/12/08, Notice 5/7/08—published 7/2/08, effective 8/6/08]

[1] Effective date of Ch 9 delayed by Administrative Rules Review Committee.

CHAPTER 21
CASE MANAGEMENT PROGRAM FOR FRAIL ELDERS

321—21.1(231) Authority. This chapter implements the case management program for frail elders (CMPFE) as provided in Iowa Code section 231.23A.

321—21.2(231) Purpose. This chapter sets out consumer eligibility, covered services, program administration and program standards to assist consumers in making appropriate use of the long-term care continuum which ranges from care in the home to institutionalization.

321—21.3(231) Definitions. Words and phrases used in this chapter are as defined in 321 IAC 1 unless the context indicates otherwise. The following definition also applies to this chapter:

"Case management program for frail elders" or *"CMPFE"* means case management activities that assist an elder in gaining access to needed medical, social, and other appropriate services. Case management services are provided at the direction of the elder and include:

1. A comprehensive assessment of the individual's needs;
2. Development and implementation of a service plan to meet those needs;
3. Coordination and monitoring of service delivery;
4. Evaluation of outcomes;
5. Periodic reassessment and revision of the service plan as needed; and
6. Ongoing advocacy on behalf of the elder.

321—21.4(231) Program administration.

21.4(1) Each AAA shall use the forms and data processing software systems specified by the department for all program requirements.

21.4(2) The department shall have complete access to all case management records maintained by the AAA.

21.4(3) Consumer-specific case management records shall be maintained by the department and the AAA as confidential information.

21.4(4) Appeals of decisions by the AAA shall follow the procedures given in 321 IAC 2.9(231).

321—21.5(231) Eligibility for CMPFE services. A person meeting all the following criteria shall be eligible for CMPFE services:

1. Resides in Iowa;
2. Is aged 60 or older;
3. Needs two or more services;
4. Does not live in, or is within 30 days of discharge from, a nursing facility as defined in Iowa Code section 135C.1(13); and
5. Is in need of case management services based on a standardized assessment of needs.

321—21.6(231) Admission into the case management program. The date of admission into the case management program for consumers shall be the date of the assessment.

321—21.7(231) Discharge from CMPFE.

21.7(1) A consumer shall be discharged from CMPFE when the AAA has determined that any one of the following situations has occurred:

a. The consumer dies;
b. The consumer moves out of state;
c. The consumer moves into a nursing facility and is expected to stay in the facility for more than 90 days;
d. The consumer or the consumer's legal representative requests termination from CMPFE;
e. The consumer is unwilling or unable to adhere to the agreed-upon service plan;
f. The consumer or the consumer's legal representative refuses to provide access to information necessary for the development or implementation of the service plan;
g. The consumer's needs cannot be met in a way that ensures the consumer's health, safety and welfare; or
h. The consumer's goals are achieved and the consumer no longer needs case management.

21.7(2) The CMPFE coordinator shall approve all recommendations for discharge prior to initiation of discharge action.

21.7(3) If the discharge is due to the circumstances given in subrule 21.7(1), paragraphs *"e"* through *"h,"* the case manager shall provide a written notice to the consumer or the consumer's legal representative stating the reasons for the discharge from case management and include the process for appealing the decision.

321—21.8(231) Organizational requirements.

21.8(1) Each AAA shall develop and adhere to written procedures regarding the prevention and management of conflicts of interest. Such procedures shall at a minimum include:

a. The process for delegating case management responsibilities to a case manager;

b. Identification of where conflicts do, or could, exist;

c. Procedures to eliminate or minimize those conflicts;

d. A process for conflict resolution with the consumer's best interest as the priority.

21.8(2) Each AAA shall have a designated CMPFE coordinator responsible for administering and monitoring the program at the local level.

21.8(3) Each AAA shall ensure that all CMPFE staff complete mandatory reporter training requirements in accordance with Iowa Code chapter 235B.

321—21.9(231) Personnel qualifications. After July 1, 2006, the following are minimum training, education and work history requirements for AAA and contract personnel in the CMPFE program:

21.9(1) *Case manager qualifications for employment.*

a. The case manager shall hold a bachelor's degree in the human services field. The case manager may substitute up to two years' full-time equivalent work experience in a human services field involving direct contact with people in overcoming social, economic, psychological or health problems for two years of the educational requirement; or

b. The case manager shall be currently licensed as a registered nurse in Iowa.

21.9(2) *CMPFE coordinator qualifications for employment.*

a. The CMPFE coordinator shall hold a bachelor's degree in the human services field and have one year of full-time equivalent work experience in a human services field involving direct contact with people in overcoming social, economic, psychological or health problems; or

b. The CMPFE coordinator shall be a licensed registered nurse and have one year of full-time equivalent experience in a health care field involving direct contact with people in overcoming social, economic, psychological or health problems.

21.9(3) *Training required during employment.*

a. The case manager shall attend case management orientation required by the department within six months of beginning employment with an AAA.

b. All case managers shall:

(1) Receive formal training from the AAA CMPFE coordinator in completion of the CMPFE assessment tools; and

(2) Attend six hours of department-approved long-term care or aging-related training per year.

c. All CMPFE coordinators shall attend case management coordinator training provided by the department within three months of beginning employment with an AAA.

d. All CMPFE coordinators shall:

(1) Receive formal training from the department's CMPFE program manager in completion of the CMPFE assessment tools; and

(2) Attend six hours of department-approved long-term care or aging-related training per year.

321—21.10(231) Covered services. Case management services may vary by consumer but shall include comprehensive screening and assessment of the consumer's needs, development and implementation of a written service plan, ongoing monitoring to ensure that services specified in the plan are being provided, and ongoing advocacy on behalf of the consumer.

321—21.11(231) Assessment of consumer needs. The assessment of consumer needs shall be conducted in person and shall, at a minimum, consist of:

21.11(1) Obtaining the consumer's signature on a standard release of information form which documents the consumer's permission to share information for assessment and case management.

21.11(2) Conducting a comprehensive assessment using the assessment tool designated by the department.

21.11(3) Contacting sources for additional information to complete the assessment tool as needed.

321—21.12(231) Service plan development.

21.12(1) Upon completion of the comprehensive assessment during the home visit, the case manager shall develop an initial service plan with the consumer which, at a minimum, shall take into consideration and address information identified during the assessment of the consumer's service needs, functioning level, strengths and available family or informal service providers and community resources. The case manager shall provide the consumer with a list of known service providers available in the consumer's community.

21.12(2) Following the initial plan, a more thorough, ongoing plan shall be developed. The completed written service plan shall include at a minimum:

a. A description of the level of care;

b. Goals to be obtained by the consumer;

c. Expected outcomes;

d. Services to be provided, providers of those services and the frequency and cost of services, if available; and

e. Exit and contingency planning.

21.12(3) The case manager shall explain to the consumer how to access assistance in situations of suspected dependent adult abuse.

21.12(4) The consumer or the consumer's legal representative and the case manager shall sign the service plan.

21.12(5) Each AAA shall have a written process in place to ensure that service plans meet all applicable standards.

321—21.13(231) Monitoring. In order to ensure consumer health, safety and welfare, the case manager shall:

1. Monitor the provision of services on an ongoing basis;
2. Hold an individual face-to-face meeting with the consumer at least quarterly to review the service plan and services provided; and
3. Document in the consumer's case files all contacts and case management activities undertaken on behalf of the consumer.

321—21.14(231) Reassessment.

21.14(1) A reassessment shall be conducted whenever there is a significant change in the consumer's status or at least every 12 months. The reassessment shall include review and modification of the information contained in the most recent assessment.

21.14(2) The service plan shall be revised to reflect changes, deletions or additions to services based on any changes in the consumer's needs.

321—21.15(231) Confidentiality. Except by written consent of the consumer or the consumer's legal representative, the use or disclosure by any person of any information concerning a consumer for any purpose not directly connected with the administration of the responsibilities of the department, AAA or authorized service provider is prohibited.

321—21.16(231) Contracting for case management services.

21.16(1) AAA may choose to contract with local provider agencies for delivery of case management services. If the AAA contracts for case management services, the AAA shall have written procedures established under 321 IAC 6.9(231) that create a framework for ongoing review of how the contract agency is meeting program standards and the terms of the contract. The department shall audit AAA procedures to ensure that the area agency's monitoring is sufficient and timely.

21.16(2) Provider agencies shall meet all program organization and personnel requirements of this chapter.

21.16(3) The following requirements shall be in place to ensure that service plan development is conducted in the best interest of the consumer:

a. When assigning a consumer to a case management entity under contract, the AAA shall make all reasonable efforts to assign the consumer to an agency not currently providing direct services to that particular consumer in an effort to avoid potential conflicts of interest.

b. If the case manager is employed by the same agency that provides other direct services to the consumer, the case manager shall discuss with the consumer or the consumer's legal representative the issue of potential conflict of interest. The case manager shall inform the consumer that the consumer has free choice of providers and that selection of any particular provider will not influence the services provided by the case manager. The conversation and the consumer's response shall be documented in the case notes.

c. When explaining provider options, the case manager shall include, at a minimum, the name, address, and telephone number of the potential provider agencies; the types of services provided; and the frequency and units of service the consumer would be able to receive if there is a cost differential between providers of the same service.

21.16(4) The AAA must have a written plan completed to monitor adherence by case management providers to the standards in subrule 21.16(3). Contracts must contain provisions that require case management providers to have written conflict of interest policies that include but are not limited to:

a. Specific procedures to identify where conflicts could exist;

b. Procedures to eliminate or minimize the conflicts upon identification of situations that might indicate that a conflict of interest could exist;

c. Steps that must be taken to resolve the issue when a conflict of interest arises or a complaint of conflict of interest is received; and

d. Written documentation or follow-up letters that show that the outcome was satisfactory to all parties involved.

321—21.17(231) Severability. Should any rule, subrule, paragraph, phrase, sentence or clause of this chapter be declared invalid or unconstitutional for any reason, the remainder of this chapter shall not be affected thereby.

These rules are intended to implement 2005 Iowa Acts, chapter 167, section 14, and Iowa Code section 231.23A.

[Filed 5/5/06, Notice 1/4/06—published 5/24/06, effective 7/1/06]
[Filed 6/12/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]

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Rescinded IAB 4/14/04, effective 5/19/04

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HUMAN SERVICES DEPARTMENT[441]

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

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[Prior to 7/1/83, Social Services[770] Ch 41]
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DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—41.1 to **41.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, Human Services(441—41.1 to 41.9)]

441—41.21(239B) Eligibility factors specific to child.

41.21(1) *Age.* The family investment program shall be available to a needy child under the age of 18 years without regard to school attendance.

A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month. The family investment program shall also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, as defined in paragraph 41.24(2)*"e,"* and who is reasonably expected to complete the program before reaching the age of 19.

41.21(2) Rescinded, effective June 1, 1988.

41.21(3) *Residing with relative.* The child shall be living in the home of one of the relatives specified in subrule 41.22(3). When an unwed mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

41.21(4) Rescinded, effective July 1, 1980.

41.21(5) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code sections 239B.1, 239B.2 and 239B.5.

441—41.22(239B) Eligibility factors specific to payee.

41.22(1) Reserved.

41.22(2) Rescinded, effective June 1, 1988.

41.22(3) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father—adoptive father.

Mother—adoptive mother.

Grandfather—grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather—adoptive grandfather.

Grandmother—grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother—adoptive grandmother.

Great-grandfather—great-great-grandfather.

Great-grandmother—great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother—brother-of-half-blood—stepbrother—brother-in-law—adoptive brother.

Sister—sister-of-half-blood—stepsister—sister-in-law—adoptive sister.

Uncle—aunt, of whole or half blood.

Uncle-in-law—aunt-in-law.

Great uncle—great-great-uncle.

Great aunt—great-great-aunt.

First cousins—nephews—nieces.

Second cousins, meaning the son or daughter of one's parent's first cousin.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

c. The family investment program is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

d. The presence of an able-bodied stepparent in the home shall not disqualify a child for assistance, provided that other eligibility factors are met.

41.22(4) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity.

a. When necessary to establish eligibility, the local office shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family investment program family or other sources of information 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 local office shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.22(5) *Referral to child support recovery unit.* The county office shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

"Prompt notice" means within two working days of the date assistance is approved.

41.22(6) *Cooperation in obtaining support.* Each applicant for or recipient of the family investment program shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in 41.22(8) for refusal to cooperate is established.

a. The applicant or recipient shall cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

(4) Rescinded IAB 12/3/97, effective 2/1/98.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the local office or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

(4) Paying to the department any cash support payments for a member of the eligible group, except as described at 41.27(7)*"p"* and *"q,"* received by a recipient after the date of decision as defined in 441—subrule 40.24(4).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the local office in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. In the circumstance as described at paragraph *"b,"* subparagraph (4), the income maintenance unit in the county office shall make the determination of whether or not the client has cooperated. In all other instances, the child support recovery unit (CSRU) shall make the determination of whether the client has cooperated. CSRU delegates the income maintenance unit in the county office to make this determination for applicants.

f. Failure to cooperate shall result in a sanction to the family. The sanction shall be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction shall be implemented after the noncooperation has occurred. The sanction shall remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction shall be delayed until cooperation has occurred.

(2) When the child support recovery unit (CSRU) makes the determination, the sanction shall be implemented upon notification from CSRU to the income maintenance unit that the client has failed to cooperate. The sanction shall remain in effect until the client has expressed to either income maintenance or CSRU staff willingness to cooperate. However, any action to remove the sanction shall be delayed until income maintenance is notified by CSRU that the client has cooperated.

41.22(7) *Assignment of support payments.* Each applicant for or recipient of assistance shall assign to the department any rights to support from any other person as the applicant or recipient may have. This shall include rights to support in the applicant's or recipient's own behalf or in behalf of any other family member for whom the applicant or recipient is applying or receiving assistance and which have accrued at the time the assignment is executed. An assignment is effective the same date the county office enters all eligibility information into the department's computer system and is effective for the entire period for which assistance is paid.

a. Rescinded IAB 11/8/06, effective 1/1/07.

b. Rescinded IAB 7/1/98, effective 7/1/98.

c. and *d.* Reserved.

e. Rescinded IAB 12/3/97, effective 2/1/98.

41.22(8) *Good cause for refusal to cooperate.* Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The local office shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought; or

(2) Emotional harm to the child for whom support is to be sought; or

(3) Physical harm to the parent or caretaker relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The local office shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the local office believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

41.22(9) *Claiming good cause.* Each applicant for or recipient of the family investment program who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Prior to requiring cooperation, the county office shall notify the applicant or recipient on Form 470-0169, Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination. One copy of this form shall be given to the applicant or recipient and one copy shall be signed by the applicant or recipient and the worker and filed in the case record.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the family investment program.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed; and that if the local office determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the local office will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the county office shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. When the applicant or recipient chooses to claim good cause, Form 470-0170 shall be signed and dated by the client and returned to the county office. This form:

(1) Indicates that the applicant or recipient must provide corroborative evidence of a good cause circumstance and must, when requested, furnish sufficient information to permit the local office to investigate the circumstances.

(2) Informs the applicant or recipient that, upon request, the local office will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the local office will determine whether cooperation would be against the best interest of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that the child support recovery unit may review the local office's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the local office determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the local office to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

41.22(10) *Determination of good cause.* The local office shall determine whether good cause exists for each applicant for or recipient of the family investment program who claims to have good cause.

a. The applicant or recipient shall be notified by the local office of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the local office's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The local office may exceed this time standard only when:

(1) The case record documents that the office needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in 41.22(11).

c. When the local office determines that good cause does not exist:

(1) The applicant or recipient will be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The local office shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after it has examined the evidence and found that it actually verifies the good cause claim.

e. Prior to making a final determination of good cause for refusing to cooperate, the local office shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The local office shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

41.22(11) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the local office determines the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the local office shall allow a reasonable additional period of time upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

(4) Medical records which indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the local office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the local office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the local office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The local office will 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 will be found when the claimant's statement and investigation which is conducted satisfies the office that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The local office may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the local office determines that it is necessary, it 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 local office will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.22(12) *Enforcement without caretaker's cooperation.* When the local office makes a determination that good cause exists, it shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve their participation.

a. Prior to making the determination, the child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the local office shall consider any recommendation from the unit.

b. The determination shall be in writing, contain the local office's findings and basis for determination, and be entered into the family investment program case record.

c. When the local office excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, it will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.22(13) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement shall not apply to a payee who is not a member of the eligible group.

a. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of 41.22(13).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described at 41.23(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.22(14) *Department of workforce development registration and referral.* Rescinded IAB 11/1/00, effective 1/1/01.

41.22(15) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive family investment program benefits unless good cause for not living with the parent or legal guardian is established. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium

or same row house as the adult parent or legal guardian. It also includes living in an apartment which is located in the home of the adult parent or legal guardian.

For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described at 441—subrule 40.24(2). If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child shall be approved as early as seven days from receipt of the application provided they are otherwise eligible. For pending applications that have already had the first interview before this subrule is implemented, the department shall determine eligibility in accordance with 441—subrule 40.24(4). If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child shall be denied. For recipients, when changes occur, continuing eligibility shall be redetermined according to 441—subrules 40.27(4) and 40.27(5).

A minor parent determined to have good cause for not living with a parent or legal guardian must attend FaDSS or other family development as required in 441—subrule 93.109(2).

41.22(16) *Good cause for not living in the home of a parent or legal guardian.* Good cause shall exist when at least one of the following conditions applies:

a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.

b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following shall be considered:

1. The present emotional state of the individual subject to emotional harm.
2. The emotional health history of the individual subject to emotional harm.
3. Intensity and probable duration of the emotional impairment.

c. The minor parent is in a foster care supervised apartment living arrangement.

d. The minor parent is participating in the job corps solo parent program.

e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department of human services.

g. Other circumstances exist which indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations which appear to meet this good cause reason must be referred to the administrator of the division of economic assistance, or the administrator's designee, for determination of good cause.

41.22(17) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian shall have the opportunity to claim good cause for not living with a parent or legal guardian.

41.22(18) *Determination of good cause for not living in the home of a parent or legal guardian.* The county office shall determine whether good cause exists for each applicant or recipient who claims good cause.

a. The applicant or recipient shall be notified by the county office of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the county office's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. When the county office determines that good cause does not exist:

(1) The applicant or recipient shall be so notified.

(2) The application shall be denied or family investment program assistance canceled.

(3) Rescinded IAB 8/31/05, effective 11/1/05.

c. The county office shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.22(19) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described at 441—subrule 40.24(1) and paragraph 40.27(4)*"c."*

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim. Written statements from the client's friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records which verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When after examining the corroborative evidence submitted by the applicant or recipient, the county office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the county office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the county office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents.

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

This rule is intended to implement Iowa Code chapter 239B.

441—41.23(239B) Home, residence, citizenship, and alienage.

41.23(1) *Iowa residence.*

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.23(2) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

41.23(3) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the assistance unit, except as described in paragraph *"b."*

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as defined for children in 41.24(2)*"e"* and for adults in 441—subrule 93.114(1), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code section 239B.2 and who meets either of the following requirements shall be eligible for participation in the family investment program:

a. The person is a conditional resident alien who was battered or subjected to extreme cruelty, or whose child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, as described in 8 CFR Section 216.5(a)(3).

b. The person was battered or subjected to extreme cruelty, or the person's child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, and the person's petition has been approved or a petition is pending that sets forth a prima facie case that the person has noncitizen status under any of the following categories:

(1) Status as a spouse or child of a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(1)(A).

(2) Status as a spouse or child who was battered or subjected to extreme cruelty by a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(iii), as codified in 8 United States Code Section 1154(a)(1)(A)(iii).

(3) Classification as a person lawfully admitted for permanent residence under the federal Immigration and Nationality Act.

(4) Suspension of deportation and adjustment of status under the federal Immigration and Nationality Act, Section 244(a), as in effect before the date of enactment of the federal Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

(5) Cancellation of removal or adjustment of status under the federal Immigration and Nationality Act, Section 240A, as codified in 8 United States Code Section 1229b.

(6) Status as an asylee, if asylum is pending, under the federal Immigration and Nationality Act, Section 208, as codified in 8 United States Code Section 1158.

41.23(5) *Citizenship and alienage.*

a. A family investment program assistance grant may include the needs of a citizen or national of the United States, or a qualified alien as defined at 8 United States Code Section 1641.

(1) A person who is a qualified alien as defined at 8 United States Code Section 1641 is not eligible for family investment program assistance for five years. The five-year period of ineligibility begins on the date of the person's entry into the United States with a qualified alien status as defined at 8 United States Code Section 1641.

EXCEPTIONS: The five-year prohibition from family investment program assistance does not apply to battered aliens as described at 41.23(4), qualified aliens described in 8 United States Code Section 1612, or to qualified aliens as defined at 8 United States Code Section 1641 who entered the United States before August 22, 1996.

(2) A person who is not a United States citizen, a battered alien as described at 41.23(4), or a qualified alien as defined at 8 United States Code Section 1641 is not eligible for the family investment program regardless of the date the person entered the United States.

b. As a condition of eligibility, each applicant shall attest to the applicant's citizenship or alien status by signing Form 470-0462 or 470-0466, Health and Financial Support Application, or Form 470-2549, Statement of Citizenship Status.

(1) The applicant or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf shall sign the form. When both parents are in the home, both shall sign a form attesting to their citizenship.

(2) An adult shall sign the form for dependent children. Form 470-2881, Review/Recertification Eligibility Document, may be used to attest to the citizenship of dependent children who enter a recipient household.

(3) Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligibility group.

This rule is intended to implement Iowa Code sections 239B.2 and 239B.2B.

441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. An application for assistance constitutes a registration for the program for all members of the family investment program (FIP) case. Persons who are not exempt from referral to PROMISE JOBS shall enter into a family investment agreement (FIA) as a condition of receiving FIP, except as described at subrule 41.24(8).

41.24(1) *Referral to PROMISE JOBS.*

a. All persons whose needs are included in a grant under the FIP program shall be referred to PROMISE JOBS as FIA-responsible persons unless the county office determines the persons are exempt.

b. Any parent living in the home of a child receiving a grant shall also be referred to PROMISE JOBS as an FIA-responsible person unless the county office determines the person is exempt.

c. All applicants shall be referred to PROMISE JOBS as FIA-responsible persons unless the local office determines that the person is exempt or does not meet other FIP eligibility requirements.

d. Applicants who have chosen and are in a limited benefit plan that began on or after June 1, 1999, shall complete significant contact with or action in regard to PROMISE JOBS as described at paragraphs 41.24(8)*"a"* and *"d"* for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent meets the exemption criteria described at subrule 41.24(2).

41.24(2) *Exemptions.* Except as specified at subrule 41.30(3), the following persons are exempt from referral:

a. and *b.* Rescinded IAB 12/3/97, effective 2/1/98.

c. A person who is under the age of 16 and is not a parent.

d. A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.

e. A person who is aged 16 to 19, and is not a parent, who attends an elementary, secondary or equivalent level of vocational or technical school full-time. For persons who lose exempt status for not attending school and who are referred to PROMISE JOBS on or after November 1, 2005, once the person has signed a family investment agreement, the person shall remain referred to PROMISE JOBS and subject to the terms of the agreement.

(1) A person shall be considered to be attending school full-time when enrolled or accepted in 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 person shall also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, 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 person's education is temporarily interrupted pending adjustment of the education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

f. A person who is not a United States citizen and is not a qualified alien as defined in 8 United States Code Section 1641 or a battered alien as described at 41.23(4).

41.24(3) *Parents aged 19 and under.*

a. Unless exempt as described at subrule 41.24(2), parents aged 18 or 19 are referred to PROMISE JOBS as follows:

(1) A parent aged 18 or 19 who has not successfully completed a high school education (or its equivalent) shall be required to participate in educational activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in other PROMISE JOBS options if the person fails to make good progress in completing educational activities or if it is determined that participation in educational activities is inappropriate for the parent.

(3) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

b. Unless exempt as described at subrule 41.24(2), parents aged 17 or younger are referred to PROMISE JOBS as follows:

(1) A parent aged 17 or younger who has not successfully completed a high school education or its equivalent shall be required to participate in high school completion activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

41.24(4) *Method of referral.*

a. While the eligibility decision is pending, applicants in a limited benefit plan that began on or after June 1, 1999, shall receive a letter which contains information about the need to complete significant contact with or action in regard to the PROMISE JOBS program to be eligible for FIP assistance and the procedure for being referred to the PROMISE JOBS program.

b. While the eligibility decision is pending, applicants who must qualify for a hardship exemption before approval of FIP shall be treated in accordance with subrule 41.30(3).

c. Each person required to be referred to PROMISE JOBS as described at subrule 41.24(1) must meet with PROMISE JOBS staff and sign an FIA.

(1) For an applicant filing an application on or after September 1, 2004, the FIA must be signed before FIP approval, as a condition of eligibility. If a parent fails to sign an FIA, the entire family is ineligible for FIP. If a referred person who is not a parent fails to sign an FIA, only that person is ineligible.

(2) When a FIP participant loses exempt status, the FIP participant shall receive a letter which contains information about participant responsibility under PROMISE JOBS and the FIA and instructs the FIP participant to contact PROMISE JOBS within ten calendar days to schedule the PROMISE JOBS orientation.

41.24(5) *Changes in status and redetermination of exempt status.* Any exempt person shall report any change affecting the exempt status to the county office within ten days of the change. The county office shall reevaluate exempt persons when changes in status occur and at the time of six-month or annual review. The recipient and the PROMISE JOBS unit shall be notified of any change in a recipient's exempt status.

41.24(6) *Volunteers.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(7) *Referral to vocational rehabilitation.* The department shall make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) *The limited benefit plan (LBP).* When a participant responsible for signing and meeting the terms of a family investment agreement as described at rule 441—93.109(239B) chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant shall enter into a limited benefit plan. A limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to the participant as defined at 441—subrule 7.7(1). Once the limited benefit plan is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose a limited benefit plan, the person who chose the limited benefit plan can reconsider and end the limited benefit plan, but only as described at paragraph 41.24(8)*"d."* A participant who is exempt from PROMISE JOBS is not subject to the limited benefit plan.

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of the limited benefit plan, for a first limited benefit plan, the FIP household shall not be eligible until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph *"d."* If a subsequent limited benefit plan is chosen by the same participant, a six-month period of ineligibility applies and ineligibility continues after the six-month period is over until the participant who chose the LBP completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph *"d."* A limited benefit plan imposed in error as described in paragraph *"f"* shall not be considered a limited benefit plan. A limited benefit plan is considered imposed when timely and adequate notice is issued establishing the limited benefit plan.

b. The limited benefit plan shall be applied to participants responsible for the family investment agreement and other members of the participant's family as follows:

(1) When the participant responsible for the family investment agreement is a parent, the limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1).

(2) When the participant choosing a limited benefit plan is a needy specified relative or a dependent child's stepparent who is in the FIP eligible group because of incapacity, the limited benefit plan shall apply only to the individual participant choosing the plan. EXCEPTION: The limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1) when a needy specified relative who assumes the role of parent was responsible for the family investment agreement and chose a limited benefit plan effective October 1, 2005, or earlier.

(3) When the FIP eligible group includes a minor parent living with the minor parent's adult parent or needy specified relative who receives FIP benefits and both the minor parent and the adult parent or needy specified relative are responsible for developing a family investment agreement, each parent or needy specified relative is responsible for a separate family investment agreement, and the limited benefit plan shall be applied as follows:

1. When the adult parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the entire eligible group, even though the minor parent has not chosen the limited benefit plan. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the family investment agreement process.

2. When the minor parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the minor parent and any child of the minor parent.

3. When the minor parent is the only eligible child in the adult parent's or needy specified relative's home and the minor parent chooses the limited benefit plan, the adult parent's or needy specified relative's FIP eligibility ceases in accordance with subrule 41.28(1). The adult parent or needy specified relative shall become ineligible beginning with the effective date of the minor parent's limited benefit plan.

4. When the needy specified relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply as described at subparagraph 41.24(8)*"b"*(2).

(4) When the FIP eligible group includes children who are mandatory PROMISE JOBS participants, the children shall not have a separate family investment agreement but shall be asked to sign the eligible group's family investment agreement and to carry out the responsibilities of that family investment agreement. A limited benefit plan shall be applied as follows:

1. When the parent or needy specified relative responsible for a family investment agreement meets those responsibilities but a child who is a mandatory PROMISE JOBS participant chooses an individual limited benefit plan, the limited benefit plan shall apply only to the individual child choosing the plan.

2. When the child who chooses a limited benefit plan under numbered paragraph "1" above is the only child in the eligible group, the parents' or needy specified relative's eligibility ceases in accordance with subrule 41.28(1). The parents or needy specified relative shall become ineligible beginning with the effective date of the child's limited benefit plan.

(5) When the FIP eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are mandatory PROMISE JOBS participants, the children are responsible for completing a family investment agreement. If a child who is a mandatory PROMISE JOBS participant chooses the limited benefit plan, the limited benefit plan shall be applied in the manner described in subparagraph (4).

(6) When both parents of a FIP child are in the home, a limited benefit plan shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for a family investment agreement and that parent chooses the limited benefit plan, the limited benefit plan applies to the entire family and cannot be ended by the voluntary participation in a family investment agreement by the exempt parent.

2. When both parents of a child in the eligible group are responsible for a family investment agreement, both are expected to sign the agreement. If either parent chooses the limited benefit plan, the limited benefit plan cannot be ended by the participation of the other parent in a family investment agreement.

3. When the parents from a two-parent family in a limited benefit plan separate, the limited benefit plan shall follow only the parent who chose the limited benefit plan and any children in the home of that parent.

4. A subsequent limited benefit plan applies when either parent in a two-parent family previously chose a limited benefit plan.

c. A participant shall be considered to have chosen a limited benefit plan under any of the following circumstances:

(1) A participant who does not establish an orientation appointment with the PROMISE JOBS program as described at 441—subrule 93.105(2) or who fails to keep or reschedule an orientation appointment shall receive one reminder letter which informs the participant that those who do not attend orientation have elected to choose the limited benefit plan. A participant who does not establish an orientation appointment within ten calendar days from the mailing date of the reminder letter or who fails to keep or reschedule an orientation appointment shall receive notice establishing the limited benefit plan. Timely and adequate notice provisions as in 441—subrule 7.7(1) apply.

(2) A participant who chooses not to sign the family investment agreement after attending a PROMISE JOBS program orientation shall enter into the limited benefit plan as described in subparagraph (1).

(3) A participant who signs a family investment agreement but does not carry out the family investment agreement responsibilities shall be deemed to have chosen a limited benefit plan as described in subparagraph (1), whether the person signed the agreement as a FIP applicant or as a FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker's request to renegotiate the family investment agreement when the participant has not attained self-sufficiency by the date established in the family investment agreement. A limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the family investment agreement.

d. A person who chooses a limited benefit plan may reconsider that choice as follows:

(1) First limited benefit plan. A person who chooses a first limited benefit plan may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. To reconsider and end the limited benefit plan, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the family investment agreement.

Since a first limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition. To end the limited benefit plan, the person must also sign a family investment agreement, even if the person had signed an agreement before choosing the limited benefit plan.

FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.22(5) when the family investment agreement is signed before the effective date of a first limited benefit plan.

(2) Rescinded IAB 4/7/99, effective 5/31/99.

(3) Subsequent limited benefit plan. A person who chooses a subsequent limited benefit plan may reconsider that choice at any time following the required six-month period of ineligibility.

A subsequent limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to establish the limited benefit plan. Therefore, once timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition.

FIP eligibility no longer exists as of the effective date of the limited benefit plan. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the limited benefit plan because the person is not eligible to sign a family investment agreement until the six-month period of ineligibility has expired.

To reconsider and end the limited benefit plan, the person must contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities, sign a new or updated family investment agreement, and satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service, unless problems or barriers as described at rules 441—93.133(239B) and 93.134(239B) apply. The 20 hours of employment or other activity must be completed within 30 days of the date that the family investment agreement is signed, unless problems or barriers as described at rules 441—93.133(239B) and 93.134(239B) apply.

FIP benefits shall not begin until the person who chose the limited benefit plan completes the previously defined significant actions. FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

(4) For a two-parent family when both parents are responsible for a family investment agreement as described at subrule 41.24(1), a first or subsequent limited benefit plan continues until both parents have

completed significant contact or action with the PROMISE JOBS program as described in subparagraphs (1) and (3) above.

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

f. A limited benefit plan imposed in error shall not be considered a limited benefit plan. This includes any instance when participation in PROMISE JOBS should not have been required as defined in the administrative rules. Examples of instances when an error has occurred are:

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

(2) It is verified that the person considered to have chosen the limited benefit plan moved out of state prior to the date that PROMISE JOBS determined the limited benefit plan was chosen.

(3) The final appeal decision under 441—Chapter 7 reverses the decision to impose a limited benefit plan.

41.24(9) *Nonparticipation by volunteer participants.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(10) *Notification of services.*

a. The department shall inform all applicants for and recipients of FIP of the advantages of employment under FIP.

b. The department shall provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

c. The department shall provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information shall include explanations of child care assistance and transitional Medicaid.

d. The department shall inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

e. The department shall explain the LBP and the process by which FIA-responsible persons and mandatory PROMISE JOBS participants can choose the LBP or individual LBP.

f. The department shall inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department shall inform applicants for FIP benefits that a family investment agreement must be signed before FIP approval as a condition of eligibility, except as described at subrule 41.24(2).

41.24(11) *Implementation.* A limited benefit plan imposed effective on or after June 1, 1999, shall be imposed according to the revised rules becoming effective on that date. A limited benefit plan imposed effective on or before May 1, 1999, shall be imposed subject to the previous rules for the limited benefit plan. For a person who is in a limited benefit plan on May 1, 1999, the terms of the person's existing limited benefit plan shall continue until that limited benefit plan either ends or is lifted in accordance with previous limited benefit plan rules. A participant who chose a limited benefit plan under the previous policy and who then chooses a limited benefit plan that becomes effective on or after June 1, 1999, shall be subject to a subsequent limited benefit plan under the provisions of the revised rules.

441—41.25(239B) Uncategorized factors of eligibility.

41.25(1) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

41.25(2) *Duplication of assistance.* A recipient whose needs are included in a family investment program grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care, or state-funded foster care. A recipient shall not concurrently receive the family investment program and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family. Neither shall a recipient concurrently receive a grant from a public assistance program in another state. When a recipient leaves the home of a specified relative, no payment for a concurrent period shall be made for the same recipient in the home of another relative.

41.25(3) *Aid from other funds.* Supplemental aid from any other agency or organization shall be limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance shall be considered unearned income.

41.25(4) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the family investment program when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.25(5) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living shall be ineligible for the family investment program for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual shall be ineligible for the family investment program for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

(2) An individual is not participating in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The district administrator shall determine whether such a risk to the individual's physical or emotional well-being exists.

41.25(6) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.25(7) *Time limit for receiving assistance.* Rescinded IAB 7/11/01, effective 9/1/01.

41.25(8) *School attendance requirements.* Rescinded IAB 7/7/04, effective 7/1/04.

41.25(9) *Pilot diversion programs.* Assistance shall not be approved when an assistance unit is subject to a period of ineligibility as described at 441—Chapter 47.

41.25(10) *Fugitive felons, and probation and parole violators.* Assistance shall be denied to a person who is (1) convicted of a felony under state or federal law and is fleeing to avoid prosecution, custody or confinement, or (2) violating a condition of probation or parole imposed under state or federal law. The prohibition does not apply to conduct pardoned by the President of the United States, beginning with the month after the pardon is given.

This rule is intended to implement Iowa Code chapters 239B and 299.

441—41.26(239B) Resources.

41.26(1) *Limitation.* An applicant or recipient may have the following resources and be eligible for the family investment program. Any resource not specifically exempted shall be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at 41.26(1)*"n"* or *"o"* and 41.26(6)*"d,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of $4115 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in 41.26(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of $4115 of any vehicle shall be counted toward the resource limit in 41.26(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

The department shall annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2000 for applicant assistance units and $5000 for recipient assistance units. EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the $5000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described at rules 441—45.26(239B)

and 45.27(239B) and persons whose grants were suspended as in 41.27(9)*"f"* in the month prior to the month of application.

Resources of the applicant or the recipient shall be determined in accordance with subrule 41.26(2).

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined in 41.27(9)*"c"*(2) reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 41.27(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limitations unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in computing whether the eligible group's property is within the reserve defined in paragraph *"e."*

o. Nonhomestead property that produces income consistent with the property's fair market value.

41.26(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limitations.

b. Resources of the parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group shall be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income recipients shall not be counted in establishing property limitations.

e. The resources of a nonparental relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

f. and *g.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½-acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 41.26(5).

41.26(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 41.27(1)*"f"* and 41.27(7)*"ah."* The portion of any payment received representing principal is considered a

resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

41.26(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

41.26(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant/recipient owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all individuals hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

41.26(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

41.26(8) *Trusts.* The department shall determine whether assets from a trust or conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the trust agreement or order establishing a conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

b. When the local office questions whether the funds in a trust or conservatorship are available, the local office shall refer the trust or conservatorship to central office. When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments. Funds in a trust or conservatorship that are not clearly available shall be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.26(9) *Aliens sponsored by individuals.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, and inventory or supplies retained by the household shall not be considered a resource.

This rule is intended to implement Iowa Code section 239B.5.

441—41.27(239B) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility and the amount of the family investment program grant. The determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the family investment program grant, received by the eligible group and available

to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group. The amount of the family investment program grant shall be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)*"h"*(2) shall be considered as exempt income for the purpose of determining continuing eligibility, including child support as specified in paragraph 41.27(7)*"q."* Deductions and diversions shall be allowed when verification is provided. The county office shall return all verification to the applicant or recipient.

41.27(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (federal insurance contribution Act, state and federal income taxes). Net unearned income, from investment and nonrecurring lump sum payments, shall be determined by deducting reasonable income producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Rescinded, effective December 1, 1986.

c. Rescinded, effective September 1, 1980.

d. Rescinded IAB 2/11/98, effective 2/1/98.

e. Rescinded IAB 2/11/98, effective 2/1/98.

f. When the applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

g. Every person in the eligible group and any parent living in the home of a child in the eligible group shall take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph (2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits shall be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2)*"c."*

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described at 441—subrule 40.27(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

h. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, shall be treated as unearned income and deducted from the initial assistance grant(s). Any cash support payment for a member of the eligible group, except as described at 41.27(7)*"p"* and *"q,"* received by the recipient after the date of decision as defined in 441—subrule 40.24(4) shall be refunded to the child support recovery unit.

(2) Assigned support collected in a month and retained by child support recovery shall be exempt as income for determining prospective or retrospective eligibility. Participants shall have the option of withdrawing from FIP at any time and receiving their child support direct.

(3) and (4) Rescinded IAB 12/3/97, effective 2/1/98.

i. The applicant or recipient shall cooperate in supplying verification of all unearned income, as defined at rule 441—40.21(239B). When the information is available, the county office shall verify job insurance benefits by using information supplied to the department by the department of workforce development. When the county office uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day. When the client notifies the county office that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A payment adjustment shall be made when indicated. Recoupment shall be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision, Form 470-0485(C) or 470-0486(M), applicable to the payment month, whichever is later, in order to receive a payment adjustment.

j. Every person in the eligible group shall apply for and accept health or medical insurance when it is available at no cost or when the cost is paid by a third party, including the department of human services. The needs of any person who refuses to cooperate in applying for or accepting this insurance shall be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2)*"c."*

41.27(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. 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, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Rescinded IAB 12/29/99, effective 3/1/00.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined in paragraph 41.27(2)*"a"* and income diversions as defined in subrules 41.27(4) and 41.27(8), the department shall disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered in determining eligibility and the amount of the assistance grant.

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility is determined without the application of the work incentive disregard as described at subparagraphs 41.27(9)*"a"*(2) and (3).

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. Rescinded IAB 9/11/96, effective 11/1/96.

f. to *i.* Reserved.

j. 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.

k. The net profit from self-employment income in a nonhome 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.

l. 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 in subrule 41.28(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 in subrule 41.28(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

m. 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 stamp allotment in the food stamp program 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 stamp allotment in the food stamp program 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.

n. Gross income from providing child care in the applicant's or recipient's own home shall include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children. In determining profit from providing child care services in the applicant's or recipient's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the individual requests to have expenses in excess of the 40 percent considered. When the applicant or recipient requests to have actual expenses considered, profit shall be determined in the same manner as specified in 41.27(2)*"o."*

o. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services in the home, 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.

p. Rescinded IAB 6/30/99, effective 9/1/99.

q. The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—40.21(239B). A self-employed individual shall keep any records necessary to establish eligibility.

41.27(3) *Shared living arrangements.* When a family investment program parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the family investment program eligible group, exclusively for their needs, are considered income.

41.27(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.21(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within family investment program standards. The maximum income that shall be diverted to meet the needs of the ineligible child(ren) shall be the difference between the

needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in 41.27(8)*"a"*(2) and 41.27(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

41.27(5) *Income of unmarried specified relatives under age 19.* Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the grant of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents shall be treated in accordance with subparagraphs (1), (2), and (4) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) shall be treated in accordance with 41.27(8)*"c."*

(3) Rescinded IAB 4/3/91, effective 3/14/91.

(4) When the unmarried specified relative is age 18, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority.

41.27(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when utilized by the household for its own consumption.

b. The value of the coupon allotment in the food stamp program.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 41.22(3), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Rescinded IAB 2/11/98, effective 2/1/98.

t. Any income restricted by law or regulation which is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

u. The first $50 received and retained by an applicant or recipient which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility and benefit amount. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. The deposit shall be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in 41.27(2)*"a"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

ac. Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.27(1)*"h"*(2).

41.27(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for job-related expenses.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family providing foster care to a child or children when the family is operating a licensed foster home.

e. Rescinded IAB 5/1/91, effective 7/1/91.

f. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

g. Federal or state earned income tax credit.

h. Supplementation from county funds providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the family investment program, or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

i. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

j. A retroactive corrective payment.

k. The training allowance issued by the division of vocational rehabilitation, department of education.

l. Payments from the PROMISE JOBS program.

m. Rescinded, effective July 1, 1989.

n. The training allowance issued by the department for the blind.

o. Payment(s) from a passenger(s) in a car pool.

p. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

q. Rescinded IAB 11/8/06, effective 1/1/07.

r. Rescinded IAB 11/8/06, effective 1/1/07.

s. Income of a nonparental relative as defined in 41.22(3) except when the relative is included in the eligible group.

t. Rescinded IAB 11/8/06, effective 1/1/07.

u. Rescinded IAB 9/11/96, effective 11/1/96.

v. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

w. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

x. Rescinded, effective July 1, 1986.

y. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in 41.24(2)*"e."* The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

z. Income attributed to an unmarried, underage parent in accordance with 41.27(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

aa. Rescinded IAB 12/3/97, effective 2/1/98.

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. Rescinded IAB 12/3/97, effective 2/1/98.

ag. Rescinded IAB 11/8/06, effective 1/1/07.

ah. Welfare reform and regular household honorarium income. All moneys paid to a FIP household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ai. Diversion or self-sufficiency grants assistance as described at 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4)*"b"* and 41.27(1)*"f."*

ak. All census earnings received by temporary workers from the Bureau of the Census for Census 2000 during the period of April 1, 2000, through January 31, 2001.

41.27(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described at paragraph 41.27(2)*"a,"* the work incentive disregard described at paragraph 41.27(2)*"c,"* and diversions described at subrule 41.27(4).

(2) The excluded parent shall be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described at subrule 41.27(11).

(3) All remaining income of the excluded parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) to (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) Rescinded IAB 6/30/99, effective 7/1/99.

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in 41.27(8)*"b"*(1) to (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the family investment program standard of need for a family group of the same composition.

(6) The stepparent shall be allowed the work incentive disregard described at paragraph 41.27(2)*"c"* from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions in subparagraphs 41.27(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 41.27(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent shall be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described at 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parent(s), the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to 41.27(8)*"b"*(1) to (7). Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with 41.27(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to 41.27(8)*"b"*(1) to (7). Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with 41.27(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit; the self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

41.27(9) *Budgeting process.* Both initial and ongoing eligibility and benefits shall be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made shall be considered to determine eligibility for the family investment program, except income which is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview shall be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with 41.27(9)*"c"*(1) and 41.27(9)*"i,"* the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision shall be deducted from earned income, except when determining eligibility under the 185 percent test defined in 41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in 41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application shall be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in rule 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need shall then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application shall be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application shall be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the family investment program grant shall be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9)*"a"*(4).

(4) Eligibility for the family investment program for any month or partial month before the month of decision shall be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision shall be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the

month of decision, income and all circumstances except family composition in that month shall be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described at subrule 41.30(1), family investment program eligibility shall be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

(6) Rescinded IAB 11/8/06, effective 1/1/07.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

b. Ongoing eligibility.

(1) The local office shall prospectively compute eligibility and benefits when a Public Assistance Eligibility Report, Form 470-0454, 470-0455, or 470-3719(S); a Combined PAER/FAIR, Form 470-4387, 470-4387(M), or 470-4387(S); or a Review/Recertification Eligibility Document, Form 470-2881, 470-2881(M), or 470-4083 (Spanish), or 470-4083(M), is completed as described in 441—40.27(239B). All countable earned and unearned income received by the eligible group during the previous 30 days shall be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the local office shall prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Rescinded IAB 11/8/06, effective 1/1/07.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2)*"a"* and the work incentive disregard as defined in paragraph 41.27(2)*"c"* shall be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be considered as income in the month received. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at periodic intervals or intermittently shall be considered as income in the month received, except periodic or intermittent income from self-employment shall be treated as described in 41.27(9)*"i."* When the income that is subject to proration is earned, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4), 41.26(7), 41.27(8)*"b,"* and 41.27(8)*"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income shall be considered as income in the month received and counted in computing eligibility and the amount of the grant, unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the family investment program grant but including countable lump-sum income, exceeds the needs of the eligible group, the case shall be canceled or the application rejected. In addition, the eligible group shall be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation shall be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility shall begin with the month the lump sum is received.

When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4)*"f,"* recoupment shall not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by rule 441—7.7(17A) requires the action be delayed until the second calendar month following the month of change, recoupment shall not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment shall be made beginning with the month of receipt.

The period of ineligibility shall be shortened when the schedule of living costs as defined in 41.28(2) increases.

The period of ineligibility shall be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

The period of ineligibility shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the

homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum shall be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the family investment program as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment shall be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6)*"f."*

e. In any month for which an individual is determined eligible to be added to a currently active family investment program case, the individual's needs shall be included subject to the effective date of grant limitations as prescribed in 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual shall be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group shall be removed prospectively effective the first of the following month.

f. Rescinded IAB 11/8/06, effective 1/1/07.

g. When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3), (4), and (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3), (4) and (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the local office shall recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in 41.28(3) must be documented before payment shall be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment shall be included, prospectively, in each month's family investment program grant. When the special need ends, payment shall be removed prospectively. Any overpayment for a special need shall be recouped.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

k. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the family investment program as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person shall be considered prospectively in accordance with 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* Rescinded IAB 10/4/00, effective 12/1/00.

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.28(239B) or 441—46.29(239B), or who is required to be included in the eligible group according to 41.28(1)*"a"* and has failed to cooperate. This restriction applies to 41.27(4)*"a"* and 41.27(8).

This rule is intended to implement Iowa Code section 239B.7.

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act. There shall be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons shall be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

(4) Rescinded IAB 6/30/99, effective 7/1/99.

41.28(2) *Schedule of needs.* The schedule of living costs represents 100 percent of basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the standard of need defined in 441—40.21(239B). The 185 percent schedule is included for the determination of eligibility in accordance with 441—41.27(239B). The schedule of basic needs is used to determine the basic

needs of those persons whose needs are included in and are eligible for a family investment program grant. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the assistance grant, when these needs must be determined in accordance with the payment standard defined in 441—40.21(239B). The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below.

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving the family investment program assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the family investment program, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the family investment program but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the family investment program, the needs of the specified relative, when eligible, shall be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in 41.22(3), only the needs of the eligible children shall be included in the assistance grant. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources shall not be considered in determining family investment program benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant shall be computed on the basis of their comprising one eligible group. This rule shall not be construed to require that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs shall be allowed, in addition to the basic needs.

a. School expenses. Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, shall be allowed provided the allowance shall not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. Guardian/conservator fee. An amount not to exceed $10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

c. FIP special needs classroom training. Rescinded IAB 12/3/97, effective 2/1/98.

d. Job Training Partnership Act. Rescinded IAB 12/3/97, effective 2/1/98.

41.28(4) *Period of adjustment.* Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code section 239B.5.

441—41.29(239B) Composite FIP/SSI cases. When persons in the family investment program household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following rules shall apply.

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the family investment program grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the family investment program recipient, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

This rule is intended to implement Iowa Code section 239B.5.

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance shall not be provided to a FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under any state program in Iowa or in another state that is funded by the Temporary Assistance for Needy Families (TANF) block grant. The 60-month period need not be consecutive. An "adult" is any person who is a parent of the FIP child in the home, or included as an optional member under subparagraphs 41.28(1)*"b"*(1), (2) and (3). In two-parent households, the 60-month limit is determined when either parent has received assistance for 60 months. "Assistance" shall include any month for which the adult receives a FIP grant. Assistance received for a partial month shall count as a full month.

41.30(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department shall consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are supplemental security income (SSI) recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1)*"b"*(1) and (2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described at subparagraph 41.28(1)*"b"*(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent's case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department shall not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441— 45.27(239B).

(3) Rescinded IAB 1/9/02, effective 3/1/02.

(4) Rescinded IAB 1/9/02, effective 3/1/02.

e. The department shall not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent's or the specified relative's FIP case.

f. The department shall not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 United States Code Section 1151) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.30(3) *Exception to the 60-month limit.* A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. "Hardship" is defined as a circumstance that is preventing the family from being self-supporting. However, the family's safety shall take precedence over the goal of self-sufficiency.

Families with an adult as defined in subrule 41.30(1) who is not a U.S. citizen, a battered alien as described at 41.23(4), or a qualified alien under 8 United States Code Section 1641 as described in subrule 41.23(5) are prohibited from receiving more than 60 months of FIP assistance. The family of an adult who is a nonqualified alien cannot meet the requirements of paragraph *"e"* since the department is precluded from using public funds to provide a nonqualified alien with family investment agreement or PROMISE JOBS services by Iowa Code sections 239B.8 and 239B.18 and rule 441—41.24(239B).

Eligibility for the hardship exemption shall be determined on an individual family basis. A hardship exemption shall not begin until the adult in the family has received at least 60 months of FIP assistance.

a. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include, but are not limited to, the following:

(1) Domestic violence. "Domestic violence" means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.
2. Sexual abuse.
3. Sexual activity involving a dependent child.
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.
5. Threats of, or attempts at, physical or sexual abuse.
6. Mental abuse.
7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.134(1).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient shall follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance abuse issues. A family requesting a hardship exemption due to substance abuse shall be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include, but is not limited to, a child as defined in rule 441—170.1(234) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child shall take precedence over the goal of self-sufficiency.

(8) Rescinded IAB 1/8/03, effective 1/1/03.

(9) Other circumstances which prevent the family from being self-supporting.

b. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.

(2) Families determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that were known and existing before the family reached the 60-month limit shall not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

c. Requesting a hardship exemption.

(1) Families with adults as defined in subrule 41.30(1) who have or are close to having received 60 months of FIP assistance may request a hardship exemption. Requests for the hardship exemption shall be made on Form 470-3826, Request for FIP Beyond 60 Months. In addition, families that have received FIP for 60 months shall complete Form 470-0462 or Form 470-0466 (Spanish), Health and Financial Support Application, as described at rule 441—40.22(239B) as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the county office's request shall result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption shall not be accepted prior to the first day of the family's fifty-ninth month of FIP assistance. The date of the request shall be the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.30(1) who has received FIP for 60 months joins a recipient family that has not received 60 months of FIP assistance, eligibility shall continue only if the recipient family submits Form 470-3826 and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period shall continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, shall follow the parent who retains the current FIP case.

d. Determination of hardship exemption.

(1) A determination on the request shall be made as soon as possible, but no later than 30 days following the date an identifiable Form 470-3826 is received in any department of human services or PROMISE JOBS office. A written notice of decision shall be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption.

The 30-day time standard shall apply except in unusual circumstances, such as when the county office and the family have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the county office.

(2) When a Health and Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) shall apply.

(3) Income maintenance shall determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The county office shall advise the applicant or recipient about how to obtain necessary documents. Upon request, the county office shall provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter shall not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The county office shall notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family shall be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)*"c."* Failure to supply the required information or verification, or refusal by the family to authorize the county office to secure the information or verification from other sources, shall result in denial of the family's request for a hardship exemption.

(7) Rescinded IAB 12/12/01, effective 11/14/01.

(8) Rescinded IAB 12/12/01, effective 11/14/01.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month shall be eligible for reinstatement as described at 441—subrule 40.22(5) when Form 470-3826 is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When Form 470-3826 is not received before the effective date of the FIP cancellation and a Health and Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance shall be no earlier than seven days from the date of application as described at rule 441—40.26(239B).

(11) Eligibility for a hardship exemption shall last for six consecutive calendar months. EXCEPTION: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Health and Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends

on receiving a hardship exemption, the family shall submit a new Form 470-3826. A new hardship exemption determination shall be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period shall count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

e. Six-month family investment agreement (FIA). Families who request a hardship exemption shall develop and sign a six-month family investment agreement (FIA) as defined at rule 441—93.109(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA. The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption shall require a new six-month FIA. Failure to develop or sign a six-month FIA shall result in denial of the family's hardship exemption request.

Families that request a hardship exemption shall be notified verbally and shall be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days shall be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the applicant agrees to an appointment that is scheduled to take place in less than five working days.

Failure to attend a scheduled interview as required, except for reasons beyond the adult's control, shall result in a denial of the family's hardship exemption request. In two-parent families, both parents shall be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(1) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family at least once a month. These contacts need not be in person. Time and attendance reports shall be required as specified at rule 441—93.135(239B).

(2) The six-month FIA shall be renegotiated and amended under the circumstances described at 441—subrule 93.109(2).

(3) Any family that has been granted a hardship exemption and that does not follow the terms of the family's six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapters 41 and 93.

f. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 239B.

[Filed 6/23/55; amended 4/12/72, 8/30/72, 11/20/72, 12/28/72, 6/21/73, 10/24/73, 3/20/74, 7/1/74, 12/2/74, 3/21/75]
[Emergency amendments filed and effective 9/19/75—published 10/6/75]
[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed without notice 7/29/76—published 8/23/76, effective 9/27/76]
[Filed emergency 7/29/76—published 8/23/76, effective 7/29/76]
[Filed 9/29/76, Notice 8/23/76—published 10/20/76, effective 11/24/76]
[Filed 4/13/77, Notice 2/23/77—published 5/4/77, effective 6/8/77, 7/1/77]
[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]
[Filed 8/18/77, Notice 6/15/77—published 9/7/77, effective 10/12/77]
[Filed 1/16/78, Notice 9/7/77—published 2/8/78, effective 3/15/78]
[Filed 2/8/78, Notice 12/28/77—published 3/8/78, effective 4/12/78]
[Filed 6/1/78, Notice 4/19/78—published 6/28/78, effective 4/19/78]
[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 11/1/78]
[Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 11/8/78]
[Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
[Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
[Filed 1/31/79, Notice 11/29/78—published 2/21/79, effective 4/1/79]
[Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]
[Filed 6/5/79, Notice 4/4/79—published 6/27/79, effective 8/1/79]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]

[Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 9/1/79]
[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]
[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 10/1/79]
[Filed emergency after Notice 9/6/79, Notice 7/11/79—published 10/3/79, effective 10/1/79]
[Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 12/1/79]
[Filed 9/27/79, Notices 2/21/79, 4/18/79—published 10/17/79, effective 12/1/79]
[Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 1/1/80]
[Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
[Filed emergency 5/5/80—published 5/28/80, effective 5/5/80]
[Filed emergency 6/4/80—published 6/25/80, effective 6/4/80]
[Filed 6/4/80, Notice 1/9/80—published 6/25/80, effective 8/1/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed 7/3/80, Notice 5/14/80—published 7/23/80, effective 9/1/80]
[Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
[Filed 9/25/80, Notices 5/14/80, 7/23/80—published 10/15/80, effective 12/1/80]
[Filed 1/16/81, Notice 11/12/80—published 2/4/81, effective 4/1/81]
[Filed emergency 3/24/81—published 4/15/81, effective 3/24/81]
[Filed emergency 3/24/81—published 4/15/81, effective 4/1/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed without Notice 3/24/81—published 4/15/81, effective 6/1/81]
[Filed 4/23/81, Notices 2/18/81, 3/4/81—published 5/13/81, effective 7/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed emergency 9/25/81—published 10/14/81, effective 10/1/81]
[Filed emergency 10/23/81—published 11/11/81, effective 11/1/81]◊
[Filed 10/23/81, Notice 8/19/81—published 11/11/81, effective 1/1/82]
[Filed 11/20/81, Notice 10/14/81—published 12/9/81, effective 2/1/82]
[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]
[Filed 2/26/82, Notice 12/9/81—published 3/17/82, effective 5/1/82]
[Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 7/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 6/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
[Filed 6/15/82, Notice 3/17/82—published 7/7/82, effective 9/1/82]
[Filed emergency 7/1/82—published 7/21/82, effective 7/1/82]
[Filed emergency 7/30/82—published 8/18/82, effective 7/30/82]
[Filed 7/30/82, Notice 4/14/82—published 8/18/82, effective 10/1/82]
[Filed emergency 9/23/82—published 10/13/82, effective 10/1/82]
[Filed emergency 10/29/82—published 11/24/82, effective 11/1/82]◊
[Filed emergency 2/25/83—published 3/16/83, effective 3/1/83]
[Filed 2/25/83, Notice 10/27/82—published 3/16/83, effective 5/1/83]
[Filed 2/25/83, Notices 7/7/82, 9/1/82—published 3/16/83, effective 5/1/83]
[Filed emergency 3/25/83—published 4/13/83, effective 5/1/83]
[Filed 4/15/83, Notice 10/27/82—published 5/11/83, effective 7/1/83]
[Filed 4/21/83, Notice 2/16/83—published 5/11/83, effective 7/1/83]
[Filed emergency 5/20/83—published 6/8/83, effective 6/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 9/1/83—published 9/28/83, effective 9/1/83]
[Filed 9/1/83, Notice 6/22/83—published 9/28/83, effective 11/2/83]
[Filed emergency 9/26/83—published 10/12/83, effective 9/30/83]
[Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
[Filed 11/18/83, Notices 9/28/83, 10/12/83—published 12/7/83, effective 2/1/84]◊
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
[Filed 12/16/83, Notices 3/16/83, 5/11/83, 6/8/83—published 1/4/84, effective 3/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed emergency 7/13/84—published 8/1/84, effective 8/1/84]

[Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
[Filed without Notice 9/28/84—published 10/24/84, effective 12/1/84]
[Filed emergency 11/1/84—published 11/21/84, effective 11/1/84]
[Filed emergency 11/16/84—published 12/5/84, effective 12/1/84]
[Filed emergency 12/11/84—published 1/2/85, effective 1/1/85]
[Filed emergency 1/21/85—published 2/13/85, effective 2/1/85]
[Filed 1/21/85, Notice 12/5/84—published 2/13/85, effective 4/1/85]
[Filed 3/4/85, Notice 1/2/85—published 3/27/85, effective 5/1/85]
[Filed emergency after Notice 3/22/85, Notice 2/13/85—published 4/10/85, effective 4/1/85]
[Filed 3/22/85, Notices 1/30/85, 2/13/85—published 4/10/85, effective 6/1/85]
[Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed 7/26/85, Notice 6/5/85—published 8/14/85, effective 10/1/85]
[Filed emergency after Notice 11/15/85, Notice 9/25/85—published 12/4/85, effective 12/1/85]
[Filed 11/15/85, Notice 10/9/85—published 12/4/85, effective 2/1/86]
[Filed emergency after Notice 12/2/85, Notice 10/23/85—published 12/18/85, effective 1/1/86]
[Filed 3/21/86, Notice 9/25/85—published 4/9/86, effective 6/1/86]
[Filed without Notice 4/28/86—published 5/21/86, effective 7/1/86]
[Filed emergency 5/28/86 after Notice 4/9/86—published 6/18/86, effective 6/1/86]
[Filed emergency 7/25/86 after Notice 6/4/86—published 8/13/86, effective 8/1/86]
[Filed emergency 8/28/86 after Notice 7/16/86—published 9/24/86, effective 9/1/86]
[Filed 9/3/86, Notice 7/2/86—published 9/24/86, effective 11/1/86]
[Filed emergency 11/14/86 after Notice 10/8/86—published 12/3/86, effective 12/1/86]
[Filed 11/14/86, Notice 10/8/86—published 12/3/86, effective 2/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 1/15/87—published 2/11/87, effective 2/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed 11/25/87, Notice 9/23/87—published 12/16/87, effective 2/1/88]
[Filed 2/17/88, Notice 12/30/87—published 3/9/88, effective 6/1/88]
[Filed without Notice 3/17/88—published 4/6/88, effective 6/1/88]
[Filed 3/17/88, Notice 1/27/88—published 4/6/88, effective 6/1/88]
[Filed 4/22/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
[Filed 5/13/88, Notices 12/16/87, 3/23/88—published 6/1/88, effective 8/1/88]
[Filed emergency 6/9/88 after Notice 5/4/88—published 6/29/88, effective 7/1/88]
[Filed emergency 12/8/88—published 12/28/88, effective 12/8/88]
[Filed 2/16/89, Notice 1/11/89—published 3/8/89, effective 5/1/89]
[Filed emergency 4/13/89 after Notice 3/8/89—published 5/3/89, effective 5/1/89]
[Filed 4/13/89, Notices 2/22/89, 3/8/89—published 5/3/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/29/89 after Notice 5/3/89—published 7/26/89, effective 7/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 9/15/89—published 10/4/89, effective 10/1/89]
[Filed 12/15/89, Notice 7/26/89—published 1/10/90, effective 3/1/90]
[Filed emergency 2/16/90—published 3/7/90, effective 4/1/90]
[Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
[Filed emergency 5/11/90—published 5/30/90, effective 7/1/90]
[Filed 6/14/90, Notice 4/18/90—published 7/11/90, effective 9/1/90]
[Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
[Filed emergency 8/16/90 after Notice 7/11/90—published 9/5/90, effective 9/1/90]
[Filed 8/16/90, Notice 6/13/90—published 9/5/90, effective 11/1/90]
[Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
[Filed emergency 2/14/91 after Notice 1/9/91—published 3/6/91, effective 3/1/91]

[Filed emergency 3/14/91—published 4/3/91, effective 3/14/91]
[Filed without Notice 4/11/91—published 5/1/91, effective 7/1/91]
[Filed 5/17/91, Notice 3/20/91—published 6/12/91, effective 8/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]◊
[Filed emergency 10/10/91 after Notice 9/4/91—published 10/30/91, effective 11/1/91]
[Filed 11/15/91, Notice 9/18/91—published 12/11/91, effective 2/1/92]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]◊
[Filed 1/16/92, Notice 9/18/91—published 2/5/92, effective 4/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/11/93 after Notice 4/28/93—published 7/7/93, effective 7/1/93]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed 12/16/93, Notice 10/13/93—published 1/5/94, effective 3/1/94]
[Filed 2/10/94, Notice 12/8/93—published 3/2/94, effective 5/1/94]
[Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
[Filed emergency 1/11/95 after Notice 11/23/94—published 2/1/95, effective 2/1/95]
[Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]
[Filed 7/12/95, Notice 5/10/95—published 8/2/95, effective 10/1/95]
[Filed without Notice 9/25/95—published 10/11/95, effective 12/1/95]
[Filed emergency 11/16/95—published 12/6/95, effective 12/1/95]
[Filed emergency 1/10/96 after Notice 10/11/95—published 1/31/96, effective 2/1/96]
[Filed 1/10/96, Notice 10/11/95—published 1/31/96, effective 4/1/96]
[Filed 8/15/96, Notice 5/8/96—published 9/11/96, effective 11/1/96]
[Filed emergency 9/19/96—published 10/9/96, effective 9/19/96]
[Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]
[Filed 12/12/96, Notice 10/9/96—published 1/1/97, effective 3/1/97]
[Filed emergency 1/15/97—published 2/12/97, effective 3/1/97]
[Filed 3/12/97, Notice 1/1/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 3/1/98]
[Filed 12/10/97, Notice 10/8/97—published 12/31/97, effective 3/1/98]
[Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 9/1/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 5/31/99]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 6/1/99]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 6/10/99, Notice 4/21/99—published 6/30/99, effective 9/1/99]
[Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 12/8/99, Notice 11/3/99—published 12/29/99, effective 3/1/00]
[Filed emergency 3/8/00—published 4/5/00, effective 4/1/00]
[Filed 5/10/00, Notice 3/22/00—published 5/31/00, effective 8/1/00]
[Filed 6/8/00, Notice 4/5/00—published 6/28/00, effective 9/1/00]
[Filed 9/12/00, Notice 7/12/00—published 10/4/00, effective 12/1/00]
[Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]

[Filed emergency 11/14/01—published 12/12/01, effective 11/14/01]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]
[Filed 2/14/02, Notice 12/12/01—published 3/6/02, effective 5/1/02]
[Filed emergency 3/14/02—published 4/3/02, effective 4/1/02]
[Filed 4/10/02, Notice 11/14/01—published 5/1/02, effective 7/1/02]
[Filed 5/9/02, Notice 4/3/02—published 5/29/02, effective 8/1/02]
[Filed emergency 12/12/02 after Notice 10/30/02—published 1/8/03, effective 1/1/03]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed 7/1/04, Notice 1/21/04—published 7/21/04, effective 9/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
[Filed 8/12/05, Notice 6/8/05—published 8/31/05, effective 11/1/05]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed 10/20/06, Notice 8/30/06—published 11/8/06, effective 1/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 8/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
[Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]

◊ Two or more ARCs

1 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

CHAPTER 42
UNEMPLOYED PARENT

[Prior to 7/1/83, Social Services[770] Ch 42]
[Prior to 2/11/87, Human Services[498]]

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

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
DISASTER REIMBURSEMENT GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Necessary expense" means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

"Safe, sanitary, and secure" means free from disaster-related health hazards.

"Serious need" means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

441—58.2(29C) Program implementation. The disaster reimbursement grant program shall be implemented when the governor issues a declaration of a state of disaster emergency and shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

441—58.3(29C) Application for assistance. To request reimbursement for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the county emergency management coordinator along with receipts for the claimed expenses.

58.3(1) Application forms are available from county emergency management coordinators and local offices of the department of human services, as well as the Internet Web site of the department at www.dhs.iowa.gov.

58.3(2) The application includes:

a. A declaration of the household's annual income.

b. A release of confidential information to personnel involved in administering the program.

c. A certification of the accuracy of the information provided.

d. An assurance that the household had no insurance coverage for claimed items.

e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.

441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is $5,000. Reimbursement is available under the program for the following disaster-related expenses:

58.5(1) Reimbursement may be issued for personal property, including repair or replacement of the following items, based on the item's condition:

a. Kitchen items, up to a maximum of $560, including:

(1) Equipment and furnishings, up to a maximum of $560.

(2) Food, up to a maximum of $50 for one person plus $25 for each additional person in the household.

b. Personal hygiene items, up to a maximum of $30 per person and $150 per household.

c. Clothing and bedroom furnishings, up to a maximum of $875, including:

(1) Mattress, box spring, frame, and storage containers, up to a maximum of $250 per person.

(2) Clothing, up to a maximum of $145 per person.

d. Other items, including:

(1) Infant car seat, up to a maximum of $40.

(2) Dehumidifier, up to a maximum of $150.

(3) Sump pump (in a flood event only), up to a maximum of $200 installed.

(4) Electrical or mechanical repairs, up to a maximum of $300.

(5) Water heater, up to a maximum of $425 installed.

(6) Vehicle repair, up to a maximum of $500.

(7) Heating and air-conditioning systems, up to a maximum of $2,100 installed. Air conditioning is covered only with proof of medical necessity.

58.5(2) Reimbursement may be issued for home repair as needed to make the home safe, sanitary, and secure, up to a maximum of $1,000. Assistance will be denied if preexisting conditions are the cause of the damage. Reimbursement may be authorized for the repair of:

a. Structural components, such as the foundation and roof.

b. Floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

58.5(3) Reimbursement may be issued for temporary housing assistance, up to a limit of $50 per day, for lodging at a licensed establishment, such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

441—58.6(29C) Eligibility determination and payment.

58.6(1) The county emergency management coordinator or designee shall:

a. Certify the household's residence and disaster-related expenses; and

b. Submit the household's application form to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The envelope shall be marked "DRGP application."

58.6(2) Designated disaster staff in the department of human services shall:

a. Review the application.

b. Determine eligibility and the amount of payment.

c. Notify the applicant household of the eligibility decision.

d. Authorize payment to an eligible household.

441—58.7(29C) Contested cases.

58.7(1) *Reconsideration.* The household may request reconsideration of the department's decisions regarding eligibility and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the DHS Division of Results-Based Accountability, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the department's letter notifying the household of its decision.

b. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

441—58.8(29C) Discontinuance of program.

58.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the state disaster reimbursement grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) *Exhaustion of funds.* The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. "First-come, first-served" is determined by the date the application is approved for payment.

a. Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. Reserved funds. A portion of allocated funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have been awarded.

c. Untimely applications. Applications received after the program is discontinued shall be denied.

These rules are intended to implement Iowa Code chapter 29C as amended by 2007 Iowa Acts, House File 896.

441—58.9 to **58.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE
[Prior to 10/13/93, 441—58.1 to 58.11]

PREAMBLE

This division implements the emergency assistance program, which is designed to assist families who face homelessness or other types of emergencies. The purpose of the program is to provide financial assistance on behalf of a needy child or children and any other members of the household to meet needs that have been caused by an emergency and that the household is unable to fulfill. The program provides a means to deal with financial situations that threaten the health and well-being of an eligible family. It is intended to meet an immediate need that would not otherwise be met. Assistance shall not be denied even if the assistance payment will provide only a temporary resolution to an ongoing problem.

441—58.21(234) Definitions.

"Child" means a person under age 18 who has not reached majority through marriage. Emergency assistance shall continue through the month in which the child turns 18. "Child" also means a person aged 18 who is a full-time student in a secondary school or in the equivalent level of vocational or technical training, who is expected to complete the program before reaching 19 and who has not reached majority through marriage. Emergency assistance shall continue through the month in which school or training is completed. In those cases in which the child reaches 19 in the same month as the child completes school or training, emergency assistance shall continue through the month of the child's nineteenth birthday.

"Destitution" means lack of shelter because of an emergency situation.

"Emergency" means, for the purposes of this program, a situation that threatens the family's living arrangements or will result in destitution unless immediate financial assistance is provided.

"Homelessness" means the lack of a fixed and regular nighttime residence or a residence which is:

1. A supervised shelter designed to provide temporary accommodations (such as a welfare hotel or congregate shelter).
2. A halfway house or similar institution that provides temporary residence for persons intended to be institutionalized.
3. A temporary accommodation in the residence of another person.
4. A place not designed for or ordinarily used as a regular sleeping accommodation for human beings (a hallway, a bus station, a lobby or similar places).

"Household" means, for the purposes of determining income, resources and household size, the following persons living in the household. The:

1. Applicant.
2. Applicant's legal or common-law spouse.
3. Applicant's child(ren).
4. Legal or biological parent of the child(ren).
5. Applicant's child(ren)'s sibling(s) of whole or half blood or adoptive.
6. Applicant and any child under the care of the applicant when the applicant meets the definition of "relative" as defined at 441—paragraph 41.22(3)*"a."*

Persons temporarily not living with the household at the time of the interview shall not be considered members of the household.

441—58.22(234) General provisions. Emergency assistance is available to families with children (including migrant families), who are faced with a crisis situation causing a threat to the families' living arrangements. Emergency assistance is also available to children who are living on their own but who have been living, within the six months prior to applying for the program, with a relative as defined at 441—paragraph 41.22(3)*"a,"* provided an emergency exists. The program is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expended prior to the end of the fiscal year, the program will be discontinued until funding is received for the next fiscal year in accordance with rule 441—58.30(234). Emergency assistance is not intended as a substitute for regular assistance grants from an ongoing program but is intended to be the program of last resort when no other sources of assistance are available. Emergency assistance shall also be provided for that portion of an emergency need not covered by benefits from other programs due to those programs' limitations.

441—58.23(234) Application procedures.

58.23(1) *Date of application.* The date of application shall be determined by the date a signed Form 470-2762, Emergency Assistance Application, is received in any local office or department-designated site. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open. To be considered valid, the application must contain a legible name and address and must be signed.

a. The emergency assistance case record must contain a completed application for each 30-day eligibility period. Whenever an initial application is denied, withdrawn, or more than 30 days old, the household shall be required to complete a new application form.

b. At least one face-to-face interview shall be conducted before approval of the application. The face-to-face interview may be held in the county office, at a department-designated site, or in the applicant's home.

(1) The applicant may appoint an authorized representative to attend the interview if the applicant is unable to attend. The authorized representative must be a person knowledgeable of the household's circumstances.

(2) If the applicant or authorized representative fails to attend the required interview, the application shall be denied.

(3) When it is impossible to hold a face-to-face interview within the ten-day time frame for processing applications as described at 58.23(2), the county office or department designee may waive the face-to-face interview and hold a telephone conference instead.

c. The household's declaration shall be accepted except when verification is required by these rules or information appears questionable. The decision with respect to eligibility shall be based largely on information provided by the household.

58.23(2) *Time limits.* Applications shall be processed within ten calendar days from the date of receipt to resolve the household's emergency. The ten-day time standard for approval shall apply except in unusual circumstances, such as when the department and the household have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expires; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

58.23(3) *Additional information required.* When additional information or verification is required, the household shall be requested in writing to provide that information within five calendar days. The written request shall also inform the household that failure to provide the required information within five calendar days or failure to authorize the local office to secure the information from other sources will result in denial of the application. The five-day period begins the day after the date the local office issues the written request.

The five-day time limit to provide additional information shall be extended if the household is unable to obtain the information by the requested date due to circumstances beyond the household's control, such as illness, or the source who is to provide the verification causes a delay, or due to emergencies like fire, flood, etc.

58.23(4) *Basis for decision on application.* The decision with respect to eligibility for emergency assistance shall be made based on the household's circumstances as they exist on the date of the interview.

58.23(5) *Subsequent requests for assistance.* Except for verifying that an emergency exists and applying for benefits from LIHEAP, general relief, or veterans affairs, the household is not required to reverify eligibility factors for approval of additional emergency assistance payment requests made within the 30-day authorization period. The time limits for processing additional requests for assistance remain the same as initial requests.

441—58.24(234) Eligibility requirements. A household, including a migrant household, shall be eligible for emergency assistance when the following conditions are met:

58.24(1) *Existence of an emergency.* An emergency shall exist, limited to eviction, foreclosure, utility shutoff, fuel shortage, loss of heating energy supply or equipment, or homelessness. An emergency does not exist for gas or electricity shutoff when a household is approved for LIHEAP and is protected by the moratorium on disconnection between November 1 and March 31.

a. An emergency also exists when there is a potential for eviction, foreclosure, utility shutoff, fuel shortage, loss of heating energy supply or equipment, or homelessness. For a household to qualify for emergency assistance, the potential emergency shall be expected to happen within the month of application or the following month.

b. The household shall be required to provide proof that an emergency exists. Acceptable verification includes, but is not limited to:

(1) An eviction notice.
(2) A foreclosure notice.
(3) A utility shutoff notice.
(4) A written statement to verify homelessness from the party or shelter where the household is staying.
(5) Other written documentation, as needed.

c. If the amount necessary to resolve the emergency exceeds the $500 maximum payment of the emergency assistance program, the applicant must be able to verify the ability to pay the difference from other resources, or the emergency assistance application shall be denied.

58.24(2) *Income and resources.* The household's available income and resources shall be within the limits as defined at rules 441—58.26(234) and 441—58.27(234).

58.24(3) *Receipt of assistance.* The household shall not have received assistance in Iowa from the program within one year prior to the date the first payment is authorized. The 12-month period begins on the date the first payment is approved. If any household member received emergency assistance within the past 12 months, the entire household is ineligible.

58.24(4) *Child in household.* The household shall contain at least one child who is living with the household.

58.24(5) *Child in need.* To be considered in need, the child shall be destitute or be without living arrangements unless assistance is provided.

a. The child is not in destitution or need if a member of the household (including the child aged 16 or older, who is not attending elementary, secondary or the equivalent level of vocational or technical school full-time) without identified problems with participation of a temporary or incidental nature as described at rule 441—93.133(239B) or barriers to participation as described at rule 441—93.134(239B), in the 30 days before application or subsequent request for emergency assistance:

(1) Refused a job offer or training for employment.

(2) Was dismissed from a job due to the member's own actions which meet the definition of "misconduct" in rule 441—93.132(239B).

(3) Quit employment.

(4) Reduced earnings.

(5) Began participation in a strike.

(6) Chose a limited benefit plan.

b. The 30-day period of ineligibility shall begin the day after the household member reduced earnings or was dismissed from a job.

(1) When a member quits a job, participates in a strike, or refuses employment, each day the job or offer for employment remains available or the household member participates in a strike is considered a day of job refusal. In these situations, the 30-day period of ineligibility shall begin the day the person returns to the job or accepts the job offer or the day after the job or offer for employment is no longer available.

(2) When a person chooses a first limited benefit plan, each day the person fails to reconsider by contacting IM or PROMISE JOBS counts as a day of refusal. The day the person reconsiders begins the 30-day period of ineligibility. When a person chooses a subsequent limited benefit plan, the 30-day ineligibility period shall begin the day after the date on the notice of decision establishing the person's limited benefit plan.

c. Whenever the household is determined to have good cause for refusing employment, quitting employment, or reducing earnings for the family investment program, no further determination is required for the emergency assistance program. Verification of the circumstances resulting in refusal, loss, or reduction of employment is not required unless information provided appears questionable.

58.24(6) *Application for other benefits.* The household shall apply for and accept benefits for which the household may be qualified from the energy assistance, county general relief and veteran's affairs programs before approval for emergency assistance.

a. Verification that the household has met the requirements of first seeking assistance from these programs shall be documented on Form 470-2804, Disposition of Application for Other Benefits. A separate form shall be completed for each program to which the applicant is referred.

b. Emergency assistance benefits shall not be approved while an application for other benefits is pending.

c. If a household is denied general relief within 30 days before emergency assistance application, and the denial was due to failure to work off past general relief assistance, emergency assistance shall also be denied.

58.24(7) *Citizenship and alienage.* The household shall contain at least one child who meets citizenship and alienage requirements as defined at 441—subrule 41.23(5). The household shall verify the alien status of at least one child to determine if the household contains an eligible child. There is no need to reverify the alien status unless it is subject to change.

58.24(8) *Utility service connection.* Applicants shall provide verification from the utility company that all requirements to provide service have been met before payment to the utility company for utility deposits for new or reconnected service will be approved. When a household applies for emergency assistance due to a disconnect notice, the household must provide verification from the utility company that the applicant either has signed a payment plan or is not eligible for a payment plan. Failure to provide this verification shall result in denial of the emergency assistance application.

441—58.25(234) Determination of need. Needs covered are limited to rent payments, house payments (including property taxes and homeowner's insurance if included in the house payment), rent and utility deposits, utilities, and purchase, repair, or rental of heating equipment. Utilities shall include heat (electric, gas, fuel oil, wood, etc.), lights, water, sewer, and garbage, but shall not include telephone. Heating equipment shall include, but is not limited to, furnace, space heater, kerosene heater, wood stove, etc. Air conditioners shall not be funded.

441—58.26(234) Income. The household's nonexempt gross income, with the exception of the deductions specified at subrule 58.26(2), shall not exceed 100 percent of the poverty level of the Office of Management and Budget (OMB). Changes in OMB's poverty guidelines shall go into effect the second month after the changes are published. When determining income and household size, the household shall be determined as defined in rule 441—58.21(234). All income reported by the household shall be verified.

58.26(1) *Income considered.* Income considered shall include, but is not limited to, all gross income received or reasonably anticipated to be received by the household in the month of application, such as the family investment program (FIP) grant, veteran's pension, social security benefits, supplemental security income (SSI),

job insurance benefits, child support income, alimony, workers' compensation benefits, cash payments from any of the DHS diversion programs, adoption subsidies, foster care payments, retroactive payments from any source, lump-sum income, earnings from on-the-job training, work-study income, income tax refunds (if received in the month of application), loans and grants available for living expenses (including unprorated gross educational moneys received in the month of application that are not earmarked), interest income (if received in the month of application), maintenance payments, Volunteers in Service to America (VISTA) payments, gifts, refunds from rental and utility deposits, earned income credit, self-employment income (net profit expected to be received in the month of application, not annualized), earnings from employment, and earnings of a child aged 16 or over who is not attending elementary, secondary or the equivalent of vocational or technical school full-time. The following deductions shall be allowed from earned income:

a. The actual, verified amount of employment-related, nonreimbursed child care expenses incurred or reasonably expected to be incurred in the month of application. A child care deduction shall also be allowed for VISTA volunteers.

b. Allowable business expenses in a self-employment enterprise, as defined at 441—subrule 41.27(2).

58.26(2) *Exempt income.* Exempt income shall include reimbursements; earned as well as unearned income in-kind; vendor payments; earnings of a child under age 16, or age 16 or older, if the child is attending elementary, secondary or the equivalent level of vocational or technical training school full-time; training allowances designated for a specific purpose (such as those issued by the Workforce Investment Act, PROMISE JOBS, Vocational Rehabilitation Services, Food Stamp Employment and Training program, etc.); that amount of the lump sum expended for legal, medical or burial expenses; and legally obligated moneys. Legally obligated money means money that is otherwise payable to the household, but which is diverted by the provider of the payment to a third party for a household expense without the household's consent. Examples of legally obligated moneys are the amount withheld from job insurance benefits to recover an overpayment or for child support for a child not living with the household; or the amount of child support withheld from earnings for a child not living with the household.

58.26(3) *Exempt as income and resources.* Deposits into an individual development account (IDA) are exempt. The amount of the deposit is exempt as income and shall not be used in the 100 percent of poverty level eligibility test. The deposit must be deducted from nonexempt earned and unearned income that the client receives in the month of application, provided the deposit is made in the month of application. To allow a deduction, verification of the deposit must be provided within five calendar days as described in subrule 58.23(3). The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions described in 58.26(1)*"a"* and *"b"* shall be applied to earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. If the client has both earned and unearned income, the amount deposited into the IDA shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

441—58.27(234) Resources. The household's liquid resources shall not exceed $1000. Liquid resources are limited to cash on hand, money in checking, savings or credit union accounts, and savings certificates, with the following exceptions: The balance in an individual development account (IDA), including interest earned on the IDA, is exempt as a resource. Income in any given month is not counted as a resource in the same month. When liquid resources are owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the resources. When determining countable resources, the household shall be determined as defined in rule 441—58.21(234). All other resources are exempt. The household's declaration of the amount of liquid resources shall be accepted unless the declaration appears questionable or the amount declared is close to the resource limitation. The household is not required to apply its available resources toward the emergency as long as the resources are within the prescribed limits.

441—58.28(234) Payment.

58.28(1) *Maximum payment.* The maximum payment shall not exceed $500 per authorization period. This amount can be applied to a single need or to several needs, not to exceed the maximum amount. Payment shall be issued in the amount of the need, not to exceed $500. When the emergency need is greater than $500 (or more than the maximum amount still available to the applicant, if a subsequent request is being made), emergency assistance shall be approved only when the applicant provides verification that either:

a. The vendor will accept payment of up to $500 (or the maximum amount available) to resolve the emergency, or

b. Another source will supply the amount needed over and above the emergency assistance payment amount.

58.28(2) *Vendor payment.* Payment shall be issued directly to the vendor in form of a state warrant unless the vendor is a state employee.

a. Vendors shall be required to complete Form 470-2781, Approval for Vendor Payment, before payment shall be issued. The vendor shall provide a copy of IRS Form W-9, Request for Taxpayer Identification Number and Certification, if necessary, to resolve vendor name or vendor number discrepancies.

b. Form 470-2781 shall also be used to notify the vendor of the amount approved for payment. Payment is owed to the vendor in the amount approved on Form 470-2781 even if emergency assistance funds are exhausted or emergency assistance eligibility is found not to exist when system entries are made. If the household provides verification of an emergency item and the cost of the item on another document, there is no need to send Form 470-2781 to the vendor to reverify the information.

c. Payment to state employees shall be made as follows:

(1) If the emergency assistance payment is for a service, such as furnace repair, the payment is included in the vendor's regular state paycheck as extra pay.

(2) If the emergency assistance payment is for goods, such as rent, rent deposit, or purchase of heating equipment, payment to the vendor is processed in the form of a travel voucher.

58.28(3) *Authorization period.* The authorization period is limited to a period of 30 consecutive days in a 12-month period, and payment shall be approved if the request is received within that period. The 30-day authorization period begins on the date the first emergency assistance payment is approved for an eligible household. The household may be eligible for more than one payment as long as the total amount of all payments does not exceed the maximum amount and all requests for additional payments are received within the period of 30 consecutive days. Any portion of the maximum payment amount not used in the 30-day authorization period cannot be carried forward to a future authorization period.

58.28(4) *Returned warrants and donations to emergency assistance.* Any refunds of emergency assistance money shall be returned to the DHS county office. Returned funds shall be deposited back into the emergency assistance account.

a. When an emergency assistance client or vendor returns the emergency assistance warrant or returns an emergency assistance payment in the form of a money order, personal check, or cash, the county office shall accept the repayment and complete Form 470-0009, Official Receipt.

b. The department may receive refunds of rent deposits that were paid on behalf of emergency assistance clients by a combination of assistance from the emergency assistance program and other persons or organizations.

c. Donations shall be handled in the same manner as refunds and shall be deposited into the emergency assistance account.

58.28(5) *Misdirected warrants.* Replacement of an emergency assistance warrant does not apply when the warrant is inadvertently delivered to the emergency assistance client rather than the vendor, and the client endorses it with the client's own name and cashes it. This is not an overpayment, because the warrant is issued on behalf of the same client who cashed it. It is up to the vendor to pursue the matter with the post office, the place of business that cashed the warrant, or the client and to work out possible repayment arrangements.

441—58.29(234) Notification and appeals. All emergency assistance households shall be given notice with respect to the decision on their application for assistance in accordance with 441—subrule 7.7(1). Households have the right to appeal the department's decision in accordance with rule 441—7.5(17A).

441—58.30(234) Discontinuance of the emergency assistance program. The program shall be discontinued when funds have been exhausted. To ensure equitable treatment, applications for emergency assistance shall be approved on a first-come, first-served basis until all funds have been depleted. First-come, first-served is determined by the date the application is approved for payment and entered into the emergency assistance computer system.

58.30(1) *Partial payment.* Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

58.30(2) *Reserved funds.* A portion of yearly emergency assistance funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have run out.

58.30(3) *Untimely applications.* Emergency assistance applications received after the program is discontinued for the year and more than five working days before the program begins again the next year shall be denied.

441—58.31(234) Special information received from emergency assistance clients. Rescinded IAB 10/2/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 234.6.

[Filed emergency 10/12/90 after Notice 8/22/90—published 10/31/90, effective 11/1/90]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 10/10/91—published 10/30/91, effective 11/21/91]
[Filed 1/29/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed 5/14/92, Notice 3/18/92—published 6/10/92, effective 8/1/92]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed 12/16/93, Notice 10/13/93—published 1/5/94, effective 3/1/94]
[Filed 2/10/94, Notice 12/8/93—published 3/2/94, effective 5/1/94]
[Filed emergency 1/15/97—published 2/12/97, effective 3/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 9/12/02 after Notice 7/24/02—published 10/2/02, effective 10/1/02]
[Filed emergency 3/5/07—published 3/28/07, effective 3/5/07]
[Filed emergency 6/13/07 after Notice 3/28/07—published 7/4/07, effective 7/1/07]
[Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]

CHAPTER 59
UNEMPLOYED PARENT WORKFARE PROGRAM

[Prior to 7/1/83, Social Services[770] Ch 59]

Rescinded, effective 7/1/89; see 441—Chapter 93

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. Persons suspended from RCA because of a temporary increase in income expected to last for only one month, such as five weekly checks received in the budget month instead of the usual four, or due to recovery of an overpayment.

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 recipients of Medicaid 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 agreement to pay an adoption subsidy 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 under the age of 18 living in a court-approved subsidized guardianship home.* Medical assistance will be available to individuals under the age of 18 living in a court-approved subsidized guardianship home under this subrule provided they are not otherwise eligible for medical assistance under a category for which federal financial participation is available.

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 recipient 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 is currently paying an adoption subsidy for the child.

d. The state paying the adoption subsidy:

(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 of Medicaid-eligible mothers.* 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. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child lives with the mother and the mother remains eligible for Medicaid or would be eligible if she were still pregnant or qualified for emergency services for childbirth.

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

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

(2) Moneys received as a 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 paragraph 75.57(9)*"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 the following percentage 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) 85 percent effective January 1, 1989.

(2) 90 percent effective January 1, 1990.

(3) 100 percent effective January 1, 1991, and thereafter.

(4) Rescinded IAB 1/9/91, effective 1/1/91.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

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 line is published.

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.

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) Denied presumptive eligibility 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 terminated 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 recipient 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 has returned, 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. Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated no earlier than the first day of the budget month, and accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

i. Assistance shall be terminated at the close of the first or fourth month of the additional six-month period if any of the following conditions exist:

(1) The family fails to return 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 for failure to return the report timely shall be established when the family demonstrates one or more of the following conditions exist:

1. There was a serious illness or death of the recipient or a member of the recipient's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The recipient offers a good cause beyond the recipient's control.
4. There was a failure to receive the department's notification for a reason not attributable to the recipient. Lack of a forwarding address is attributable to the recipient.

(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 the following percentage 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) 110 percent effective January 1, 1993.

(2) 120 percent effective January 1, 1995, and thereafter.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

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)*"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 the two-step process 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.

(4) Rehabilitative treatment services pursuant to 441—Chapter 185.

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 twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

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 used to assess premiums will be adjusted annually on April 1.

(1) Beginning with the month of application, the monthly premium amount shall be established for a 12-month period based on projected average monthly income for the 12-month period. The monthly premium established shall not be increased for any reason during the 12-month period. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively during the 12-month period 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	$29
180% of Federal Poverty Level	$53
220% of Federal Poverty Level	$80
240% of Federal Poverty Level	$110
262% of Federal Poverty Level	$140
318% of Federal Poverty Level	$170
342% of Federal Poverty Level	$200
390% of Federal Poverty Level	$230
425% of Federal Poverty Level	$260
460% of Federal Poverty Level	$291
500% of Federal Poverty Level	$323

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
548% of Federal Poverty Level	$354
607% of Federal Poverty Level	$392
666% of Federal Poverty Level	$430
725% of Federal Poverty Level	$471
824% of Federal Poverty Level	$535

(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. Persons receiving assistance under 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.

d. For purposes of this rule, 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.

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

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 470-2304, 470-2304(S), 470-0364, 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 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information.

75.2(2) When a medical resource may be obtained by filing a claim or an application and cooperating in the processing of that claim or application, that resource shall be considered to be reasonably available, unless good cause for failure to obtain that resource is determined to exist.

a. The member, or one acting on the member's behalf, shall file a claim or submit an application for any reasonably available medical resource, and shall also cooperate in the processing of the claim or application. Failure to do so without good cause shall result in the termination of medical assistance benefits.

b. 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. 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.

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) 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.

75.2(5) When the department receives information through a cross-match with Iowa workforce development department and child support recovery files which indicates the absent parent of a Medicaid-eligible child is employed, the department shall send Form 470-0413, Obligor Insurance Questionnaire, to the absent parent in

order to obtain health insurance coverage information. If the absent parent does not respond within 15 days from the date Form 470-0413 is sent, the department shall send Form 470-2240, Employer Insurance Questionnaire, to the employer in order to obtain the health insurance coverage information.

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

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 precertified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules 191—Chapter 72. A person 65 years of age or older who is either the beneficiary of a certified long-term care policy or enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 72 and who is eligible for medical assistance under 75.1(3), 75.1(4), 75.1(5), 75.1(6), 75.1(7), 75.1(9), 75.1(12), 75.1(13), 75.1(17), 75.1(18), 75.1(23) or 75.1(27) except for excess resources may be eligible for medical assistance under this subrule if the excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule. "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's long-term care policy for qualified Medicaid long-term care services.

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

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 as defined in subrule 75.11(1) residing in the United States prior to August 22, 1996.

(3) A qualified alien who entered the United States on or after August 22, 1996, and who is:

- A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
- Granted asylum under Section 208 of the Immigration and Nationality Act;
- An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or
- A veteran with a discharge characterized as an honorable discharge and not on account of alienage, an alien who is on active duty in the Armed Forces of the United States other than active duty for training, or the veteran's spouse or unmarried dependent child.

(4) A qualified alien who entered the United States on or after August 22, 1996, and who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each recipient shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the recipient's citizenship or alien status. The form shall be signed by the recipient, or when the recipient is incompetent or deceased, someone acting responsibly on the recipient's behalf. When both parents are in the home, both shall sign the form. An adult recipient shall sign the form for dependent children. As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship status by signing the application form which contains the same declaration. As a condition of continued eligibility, recipients of SSI-related Medicaid not actually receiving SSI who have been continuous recipients since August 1, 1988, shall attest to their citizenship status by signing the application form which contains a similar declaration at time of review.

c. Except as provided in paragraph *"f,"* applicants or members who attest that they are citizens or nationals of the United States shall present satisfactory documentation of citizenship or nationality as defined in paragraph *"d"* or *"e."* An applicant or member shall have a reasonable period to obtain and provide proof of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request to obtain and provide proof is issued to an applicant or member and continues to the date when the proof is provided or the date when the department establishes that the applicant or member is no longer making a good-faith effort to obtain the proof, whichever is earlier.

(2) Medicaid eligibility shall continue for members during the reasonable period. Medicaid shall not be approved for applicants until acceptable documentary evidence is provided.

(3) A reference to a form in paragraph *"d"* or *"e"* includes any successor form.

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 who attests to status as a citizen or national of the United States 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).

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.

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
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, applicants and recipients of Medicaid in households with an absent parent shall cooperate in obtaining medical support for the applicant or recipient as well as for any other person in the household for whom Medicaid is requested and for whom the person can legally assign rights for medical support, except when good cause as defined in subrule 75.14(8) for refusal to cooperate is established.

a. The applicant or recipient 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 recipient 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 applicant or recipient:

(1) Appearing at the county office 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 recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. The applicant or recipient shall cooperate with the county office 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. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure 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 income maintenance unit in the county office shall make the determination of whether or not the client has cooperated.

75.14(2) Failure of the applicant or recipient to cooperate shall result in denial or cancellation of the person'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 applicant for or recipient of Medicaid 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 applicant for or recipient of Medicaid 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 recipient's own behalf or on behalf of any other family member for whom the applicant or recipient is applying. An assignment is effective the same date the county office enters the eligibility information 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) Referrals to the child support recovery unit for Medicaid applicants or recipients. The county office shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

"Prompt notice" means within two working days of the date assistance is approved.

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) and 75.14(5) which require the applicant or recipient to assign any rights to medical support and payments for medical care and to be referred to the child support recovery unit.

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 county office shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical 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 county office shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the county office 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 recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the 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 applicant for or recipient of Medicaid 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 county office shall notify the applicant or recipient on 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. One copy of this form shall be given to the applicant or recipient and one copy shall be signed by the applicant or recipient and the worker and filed in the case record.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed and that if the county office determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the county office will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the county office shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. When the applicant or recipient chooses to claim good cause, Form 470-0170 shall be signed and dated by the client and returned to the county office. This form:

(1) Indicates that the applicant or recipient 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 recipient that, upon request, the county office will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the county office 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 recipient that the child support recovery unit may review the county office's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the county office determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the county office to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The county office shall determine whether good cause exists for each applicant for or recipient of the Medicaid program who claims to have good cause.

a. The applicant or recipient shall be notified by the county office of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the county office'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 county office may exceed this time standard only when:

(1) The case record documents that the county office 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 county office determines that good cause does not exist:

(1) The applicant or recipient shall be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The county office shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after it has examined the evidence and found that it actually verifies the good cause claim.

e. Prior to making a final determination of good cause for refusing to cooperate, the county office shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The county office 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 recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the county office determines the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the county office shall allow a reasonable additional period of time 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 recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the county office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the county office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the county office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The county office 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 recipient 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 county office may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the county office determines that it is necessary, it 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 county office 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) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the county office makes a determination that good cause exists, it 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. Prior to making the determination, the child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the county office shall consider any recommendations from the unit.

b. The determination shall be in writing, contain the county office's findings and basis or the determination, and be entered into the case record.

c. When the county office excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, it shall notify the applicant or recipient 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.

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.

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 is a veteran or a surviving spouse of a veteran who receives a pension subject to limitation of $90 after the month of entry pursuant to 38 U.S.C. Section 5503, the veteran or the surviving spouse of a veteran shall retain $90 from the veteran's pension beginning the month after entry to a medical institution. The $90 allowance from a veteran's pension is in addition to the $50 allowance from any other income.

(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. 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.

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) Persons who may be excluded from the eligible group in determining FIP-related Medicaid eligibility. Rescinded IAB 10/8/97, effective 12/1/97.

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 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 directly.

75.21(1) *Condition of eligibility.* The recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan which the department has determined is cost-effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid-eligible persons through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

When a parent fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

a. There was a serious illness or death of the parent or a member of the parent's family.

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

c. The parent offers a good cause beyond the parent's control.

d. 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.

Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of the spouse of the employed person shall not be terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.

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) *Non-employer related health insurance plans.* Participation in a health insurance plan that is not group health insurance as defined in rule 441—75.25(249A) is not a condition of Medicaid eligibility.

75.21(3) *Cost-effectiveness.* Cost-effectiveness 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 an insurance plan for those services. When determining the cost-effectiveness of the insurance plan, the following data shall be considered:

a. The cost of the insurance premium, coinsurance and deductibles. An employer-related group health insurance plan that provides major medical coverage and costs $50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs $100 or less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.

b. The scope of services covered under the insurance plan, including exclusions for preexisting conditions, etc.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for persons covered under the insurance plan.

d. The specific health-related circumstances of the persons covered under the insurance plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.

e. Annual administrative expenditures of $50 per Medicaid recipient covered under the health insurance policy.

f. Whether the estimated savings to Medicaid for persons covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.* When it 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, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

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.

g. The person is eligible only for limited Medicaid services under the specified low-income Medicare beneficiary (SLMB) coverage group, in accordance with subrule 75.1(34).

h. Insurance coverage is being provided through the Iowa Comprehensive Health Insurance Association, 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.

75.21(6) *Duplicate policies.* When more than one cost-effective health insurance plan or policy is available, the department shall pay the premium for only one plan. The recipient may choose in which cost-effective plan to enroll. However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.

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, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If it is determined the policy 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 policyholder ten calendar days in which to provide it.

d. If the policyholder leaves the household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance coverage 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 cost-effective health insurance plans shall be determined as follows:

a. Premium payments shall begin no earlier than the first day of the month in which the Employer's Statement of Earnings, Form 470-2844, or the Health Insurance Premium Payment Application, Form 470-2875,

is received by the division of medical services or the first day of the first month in which the plan is determined to be cost-effective, whichever is later.

b. If the person is not enrolled in the 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 policy is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time prior to the current effective date of coverage.

d. In no case shall payments be made for premiums which were used as a deduction to income when determining client participation, the amount of the spenddown obligation, or for premiums due for periods of time covered prior to July 1, 1991.

The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and premiums for persons enrolled in group health insurance plans.

75.21(9) *Method of premium payment.* Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to the employer in order to circumvent a payroll deduction.

b. When the 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 policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums. The department shall issue reimbursement to the policyholder five working days prior to the policyholder'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 said withdrawals.

d. When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.

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.* Reviews of cost-effectiveness shall be completed annually or at the time of the next health insurance contract renewal date for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department. The Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, shall be used for this purpose.

Reviews of cost-effectiveness shall be completed annually for non-employer-related group health plans. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility.

Failure of the policyholder 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).

Redeterminations shall also be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full Medicaid eligibility, employment terminates or hours are reduced which affects the availability of health insurance, the insurance carrier changes, the policyholder leaves the home, or there is a decrease in the services covered under the policy. 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. A HIPP Change Report, Form 470-3007, shall accompany all premium payments.

When employment terminates, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the department shall verify whether insurance may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other insurance continuation provisions. The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose. If cost-effective, the department shall pay premiums to maintain insurance coverage for eligible Medicaid recipients after the occurrence of the qualifying 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 insurance plan and notify the recipient of the decision regarding payment of the premiums within 65 days from the date an Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875, is received. Additional time may be granted when, for reasons beyond the control of the department or the recipient, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.* An adequate notice shall be provided to the household under the following circumstances:

a. To inform the household of the initial decision on cost-effectiveness and premium payment.

b. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.

c. The policy is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective or because the recipient 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 policy 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 recipient'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.

This rule is intended to implement Iowa Code section 249A.3.

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.

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, 2008, through June 30, 2009, this average statewide cost shall be $4,342.03 per month or $142.83 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of 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 (4) of this paragraph.

(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 less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The annuity was purchased before February 8, 2006; or

(2) The annuity was purchased on or after February 8, 2006, and a condition described in 75.23(9)*"a"*(1) to (4) was 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 less 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.

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the

trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual.

For disposition of trust amounts pursuant to Iowa Code sections 633.707 to 633.711, the average statewide charges and Medicaid rates for the period from July 1, 2008, to June 30, 2009, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $3,923 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 $17,954 per month.

(5) The average statewide charge to a resident of a mental health institute is $16,363 per month.

(6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $4,975 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.

441—75.25(249A) Definitions.

"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 an applicant for or a recipient of Medicaid.

"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 recipient" shall mean a medically needy person who has completed the application process and has been assigned a certification period and spenddown amount but who has not spent down for the certification period.

"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.

"Eligible recipient" under the provisions of the medically needy program shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced excess income through spenddown to the MNIL during the certification period.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Group health insurance" shall mean any plan of, or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"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 recipient, 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 recipient 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). "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 recipient 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 eligible recipient.

"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.

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.

"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.

"Budget month" means the calendar month from which the county office uses income or circumstances of the eligible group to calculate eligibility.

"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.

"Client" shall mean an applicant or recipient of Medicaid.

"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. Eligibility for the family medical assistance program (FMAP) and FMAP-related programs shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished, except as provided in the transitional Medicaid program in accordance with subparagraph 75.1(31)*"j"*(2).

75.51(1) *Exception to time limit.* Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

75.51(2) *Cancellation for failure to return review form.* When all eligibility factors are met, assistance shall be reinstated when a completed Review/Recertification Eligibility Document, Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), is received by the county office within ten days of the date a cancellation notice is sent to the recipient because the form was incomplete or not returned.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the FMAP-related programs.

a. Reviews shall be conducted using information contained in and verification supplied with Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document.

b. Family medical assistance-related medically needy recertifications shall be conducted using information contained in and verification supplied with Form 470-3118 or 470-3118(S), Medicaid Review.

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the recipient's circumstances comes to the attention of a staff member.

75.52(3) *Forms.* Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), with the following exceptions:

a. 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 semiannual or annual review.

b. Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

75.52(4) *Recipient responsibilities.* For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The recipient shall complete Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), or Form 470-3118 or 470-3118(S), Medicaid Review, when requested by the department in accordance with these rules. The department shall supply the form to the recipient as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the local office by the fifth calendar day of the report month.

(2) When the form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the local office by the seventh day after the date it is mailed by the department.

(3) Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated no earlier than the first day of the budget month, and accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

(4) A copy of a form received by fax shall be given the same effect as the original form.

c. The recipient 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 recipients 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. Recipients 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).

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"* and for adults in 441—subrule 93.114(1), first sentence, as long as the specified relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and 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.*

a. A child under the age of 19 who is determined eligible for ongoing Medicaid under subrule 75.1(14), 75.1(15), or 75.1(28) shall retain that eligibility regardless of changes in family income or household composition until the earliest of the following dates:

(1) Twelve months after the month when the department received the household's latest application or review form;

(2) The month of the household's annual eligibility review; or

(3) The month when the child reaches age 19.

b. Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

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 county office shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family 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 county office shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, an applicant or recipient 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 recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at 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 recipient assistance units.

EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the $5,000 limit.

Resources of the applicant or the recipient shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined at subparagraph 75.57(9)*"c"*(2) reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 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) recipients shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid recipient 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 recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 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 recipient owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

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 recipient the month following the month the payment was received. When the applicant or recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

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.

Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

When the county office questions whether the funds in a conservatorship are available, the county office shall refer the conservatorship to 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. Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available. 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 county office shall return all verification to the applicant or recipient.

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, from investment and nonrecurring lump sum payments, 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 applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in 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 applicant or recipient shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A). When the information is available, the county office shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the county office 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. When the client notifies the county office 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 prior to the eligibility month or within ten days of

the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the 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.

Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

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 child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(1) Child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of an individual, not to exceed $175, or $200 in the case of a child under the age of two, per month or the going rate in the community, whichever is less.

(2) 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.

(3) 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.

(4) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(5) The expense shall be verified by receipt or a statement from the provider of care and shall be allowed when paid to any person except a parent or legal guardian of the child or another member of the eligible group, or to 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 stamp allotment in the food stamp program 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 stamp allotment in the food stamp program 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 recipient'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. In determining profit from providing child care services in the applicant's or recipient's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the individual requests to have actual expenses in excess of the 40 percent considered. When the applicant or recipient 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 recipient 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 individual shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or recipient 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 recipient, exclusively for the applicant's or recipient'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 coupon allotment in the food stamp program.

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. Rescinded IAB 2/11/98, effective 2/1/98.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or recipient 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 for Census 2000 during the period of April 1, 2000, through January 31, 2001.

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 is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) 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 in the budget month and counted in computing eligibility. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for 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 during the 30 days before the application date to project future income. EXCEPTION: If the applicant provides verification that the 30-day period specified above is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income. 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. Rescinded IAB 10/4/00, effective 10/1/00.

c. Lump sum income.

(1) Recurring lump sum income. Recurring lump sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months, except periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."* 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.

(2) 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. Nonrecurring lump sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

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 of time 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. The period of proration shall begin with the month following a ten-day notice of adverse action when the receipt of the lump sum was timely reported. The period of proration shall begin with the month following the receipt of the lump sum when the receipt of the lump sum was not timely reported. The period of proration shall be shortened when the schedule of living costs as defined at subrule 75.58(2) increases. The period of proration shall be shortened by the amount which is no longer available to the eligible group due to loss, 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.

The period of proration shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

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. 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. 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, excluding the lump sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility.

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 county office 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.

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.

[Filed 3/11/70; amended 12/17/73, 5/16/74, 7/1/74]
[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]
[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 1/31/77, Notice 12/1/76—published 2/23/77, effective 3/30/77]
[Filed 4/13/77, Notice 11/3/76—published 5/4/77, effective 6/8/77]
[Filed emergency 6/22/77—published 7/13/77, effective 7/1/77]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed emergency 7/28/78 after Notice 4/19/78—published 8/23/78, effective 7/28/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
[Filed 6/5/79, Notice 4/4/79—published 6/27/79, effective 8/1/79]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]
[Filed emergency 5/5/80—published 5/28/80, effective 5/5/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed without Notice 9/25/80—published 10/15/80, effective 12/1/80]
[Filed 12/19/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed 9/25/81, Notice 7/22/81—published 10/14/81, effective 11/18/81]
[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 12/9/81—published 2/17/82, effective 4/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 6/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
[Filed emergency 7/30/82—published 8/18/82, effective 8/1/82]
[Filed 9/23/82, Notices 6/9/82, 8/4/82—published 10/13/82, effective 12/1/82]
[Filed emergency 3/18/83—published 4/13/83, effective 4/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
[Filed 10/28/83, Notice 9/14/83—published 11/23/83, effective 1/1/84]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]

[Filed emergency 1/13/84—published 2/1/84, effective 2/8/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
[Filed emergency 1/17/85—published 2/13/85, effective 1/17/85]
[Filed without Notice 1/22/85—published 2/13/85, effective 4/1/85]
[Filed emergency 3/22/85—published 4/10/85, effective 4/1/85]
[Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
[Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
[Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
[Filed 2/21/86, Notice 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 3/21/86 after Notice 2/12/86—published 4/9/86, effective 4/1/86]
[Filed emergency 4/28/86—published 5/21/86, effective 5/1/86]
[Filed emergency 8/28/86—published 9/24/86, effective 9/1/86]
[Filed 9/5/86, Notice 6/18/86—published 9/24/86, effective 11/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed without Notice 1/15/87—published 2/11/87, effective 4/1/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed 3/26/87, Notice 2/11/87—published 4/22/87, effective 6/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 5/29/87 after Notice 4/22/87—published 6/17/87, effective 7/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed emergency after Notice 9/24/87, Notice 8/12/87—published 10/21/87, effective 10/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed emergency after Notice 10/23/87, Notice 9/9/87—published 11/18/87, effective 11/1/87]
[Filed 10/23/87, Notice 9/9/87—published 11/18/87, effective 1/1/88]
[Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
[Filed emergency 3/16/88—published 4/6/88, effective 3/16/88]
[Filed 3/17/88, Notice 1/13/88—published 4/6/88, effective 6/1/88]
[Filed emergency 4/22/88—published 5/18/88, effective 5/1/88]
[Filed 4/22/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
[Filed 6/9/88, Notice 4/20/88—published 6/29/88, effective 9/1/88]
[Filed 8/4/88, Notices 6/29/88—published 8/24/88, effective 10/1/88]◊
[Filed without Notice 9/21/88—published 10/19/88, effective 12/1/88]
[Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
[Filed emergency 11/14/88—published 11/30/88, effective 11/14/88]
[Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]
[Filed emergency 4/13/89 after Notice 3/8/89—published 5/3/89, effective 5/1/89]
[Filed 4/13/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]
[Filed 5/10/89, Notice 4/5/89—published 5/31/89, effective 8/1/89]
[Filed emergency 6/9/89 after Notice 5/3/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 10/10/89—published 11/1/89, effective 12/1/89]
[Filed 10/10/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
[Filed 12/19/89, Notice 11/1/89—published 1/10/90, effective 3/1/90]
[Filed emergency 1/10/90—published 2/7/90, effective 1/10/90]
[Filed 1/16/90, Notice 11/15/89—published 2/7/90, effective 4/1/90]
[Filed emergency 2/16/90—published 3/7/90, effective 4/1/90]
[Filed without Notice 2/16/90—published 3/7/90, effective 5/1/90]
[Filed emergency 3/14/90—published 4/4/90, effective 3/14/90]
[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]

[Filed emergency 6/20/90 after Notice 4/18/90—published 7/11/90, effective 7/1/90]
[Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
[Filed emergency 8/16/90 after Notice of 6/27/90—published 9/5/90, effective 10/1/90]
[Filed 8/16/90, Notices 6/13/90, 7/11/90—published 9/5/90, effective 11/1/90]
[Filed emergency 12/13/90—published 1/9/91, effective 1/1/91]
[Filed 2/14/91, Notice 1/9/91—published 3/6/91, effective 5/1/91]
[Filed emergency 3/14/91—published 4/3/91, effective 3/14/91]
[Filed 3/14/91, Notice 1/23/91—published 4/3/91, effective 6/1/91]
[Filed emergency 4/11/91—published 5/1/91, effective 4/11/91]
[Filed 4/11/91, Notice 2/20/91—published 5/1/91, effective 7/1/91]
[Filed emergency 5/17/91 after Notice 4/3/91—published 6/12/91, effective 7/1/91]
[Filed 5/17/91, Notices 4/3/90—published 6/12/91, effective 8/1/91]◊
[Filed emergency 6/14/91 after Notice 5/1/91—published 7/10/91, effective 7/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
[Filed emergency 9/18/91 after Notice 4/17/91—published 10/16/91, effective 10/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 12/11/91—published 1/8/92, effective 1/1/92]
[Filed emergency 12/11/91 after Notice 10/30/91—published 1/8/92, effective 1/1/92]
[Filed 12/11/92, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]
[Filed 1/15/92, Notice 11/13/91—published 2/5/92, effective 4/1/92]
[Filed 2/13/92, Notices 1/8/92—published 3/4/92, effective 5/1/92]◊
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 4/16/92 after Notice 2/19/92—published 5/13/92, effective 5/1/92]
[Filed emergency 5/14/92 after Notice 3/18/92—published 6/10/92, effective 7/1/92]
[Filed 5/14/92, Notices 3/18/92—published 6/10/92, effective 8/1/92]◊
[Filed 6/11/92, Notice 4/29/92—published 7/8/92, effective 9/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed emergency 12/1/92—published 12/23/92, effective 1/1/93]
[Filed emergency 1/14/93 after Notice 10/28/92—published 2/3/93, effective 2/1/93]
[Filed 1/14/93, Notices 10/28/92, 11/25/92, 12/9/92—published 2/3/93, effective 4/1/93]
[Filed 2/10/93, Notice 12/23/92—published 3/3/93, effective 5/1/93]
[Filed 4/15/93, Notice 2/17/93—published 5/12/93, effective 7/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed emergency 6/11/93 after Notice 4/28/93—published 7/7/93, effective 7/1/93]
[Filed 7/14/93, Notice 5/12/93—published 8/4/93, effective 10/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
[Filed without Notice 12/16/93—published 1/5/94, effective 2/9/94]
[Filed 12/16/93, Notices 10/13/93, 10/27/93—published 1/5/94, effective 3/1/94]
[Filed 2/10/94, Notices 12/8/93, 1/5/94—published 3/2/94, effective 5/1/94]◊
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
[Filed 5/11/94, Notice 3/16/94—published 6/8/94, effective 8/1/94]
[Filed 6/16/94, Notice 4/27/94—published 7/6/94, effective 9/1/94]
[Filed 9/15/94, Notice 8/3/94—published 10/12/94, effective 11/16/94]
[Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
[Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
[Filed 12/15/94, Notices 10/26/94, 11/9/94—published 1/4/95, effective 3/1/95]

[Filed 2/16/95, Notices 11/23/94, 12/21/94, 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
[Filed emergency 9/25/95—published 10/11/95, effective 10/1/95]
[Filed 11/16/95, Notices 9/27/95, 10/11/95—published 12/6/95, effective 2/1/96]
[Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed 2/14/96, Notice 1/3/96—published 3/13/96, effective 5/1/96]
[Filed 4/10/96, Notice 2/14/96—published 5/8/96, effective 7/1/96]
[Filed emergency 9/19/96—published 10/9/96, effective 9/19/96]
[Filed 10/9/96, Notice 8/28/96—published 11/6/96, effective 1/1/97]
[Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]◊
[Filed 12/12/96, Notices 9/11/96, 10/9/96—published 1/1/97, effective 3/1/97]
[Filed 2/12/97, Notice 1/1/97—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notice 1/1/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/26/97—published 5/7/97, effective 7/1/97]
[Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]
[Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
[Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]
[Filed emergency 12/10/97 after Notices 10/22/97, 11/5/97—published 12/31/97, effective 1/1/98]
[Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
[Filed 2/11/98, Notice 12/31/97—published 3/11/98, effective 5/1/98]◊
[Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed emergency 6/25/98—published 7/15/98, effective 7/1/98]
[Filed 7/15/98, Notices 6/3/98—published 8/12/98, effective 10/1/98]
[Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
[Filed emergency 12/9/98—published 12/30/98, effective 1/1/99]
[Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/15/99]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 6/1/99]
[Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 7/1/99]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 5/14/99, Notice 4/7/99—published 6/2/99, effective 8/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 6/10/99, Notice 4/21/99—published 6/30/99, effective 9/1/99]
[Filed emergency 8/12/99 after Notice 6/16/99—published 9/8/99, effective 9/1/99]
[Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed emergency 11/10/99 after Notice 10/6/99—published 12/1/99, effective 12/1/99]
[Filed emergency 12/8/99—published 12/29/99, effective 1/1/00]
[Filed 12/8/99, Notice 11/3/99—published 12/29/99, effective 2/2/00]
[Filed 12/8/99, Notice 10/6/99—published 12/29/99, effective 3/1/00]
[Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00]◊
[Filed emergency 3/8/00—published 4/5/00, effective 4/1/00]
[Filed 5/10/00, Notice 3/22/00—published 5/31/00, effective 8/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed emergency 6/8/00 after Notice 4/19/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/5/00—published 6/28/00, effective 9/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/12/00—published 10/4/00, effective 10/1/00]
[Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
[Filed 11/8/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]
[Filed emergency 12/14/00—published 1/10/01, effective 1/1/01]

[Filed 2/14/01, Notice 1/10/01—published 3/7/01, effective 5/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]◊
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]◊
[Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]
[Filed emergency 12/12/01—published 1/9/02, effective 1/1/02]
[Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
[Filed 2/14/02, Notice 12/26/01—published 3/6/02, effective 5/1/02]
[Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]◊
[Filed emergency 6/13/02—published 7/10/02, effective 7/1/02]
[Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
[Filed emergency 12/12/02—published 1/8/03, effective 1/1/03]◊
[Filed emergency 1/9/03 after Notice 11/27/02—published 2/5/03, effective 2/1/03]
[Filed 1/9/03, Notice 11/27/02—published 2/5/03, effective 4/1/03]
[Filed emergency 3/14/03—published 4/2/03, effective 4/1/03]
[Filed without Notice 5/16/03—published 6/11/03, effective 7/16/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 10/10/03—published 10/29/03, effective 10/10/03]
[Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
[Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
[Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
[Filed emergency 3/11/04—published 3/31/04, effective 4/1/04]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed emergency 9/23/04 after Notice 7/7/04—published 10/13/04, effective 10/1/04]
[Filed 10/8/04, Notice 7/7/04—published 10/27/04, effective 12/1/04]
[Filed 10/14/04, Notice 8/4/04—published 11/10/04, effective 1/1/05]
[Filed emergency 12/14/04—published 1/5/05, effective 1/1/05]
[Filed emergency 1/13/05 after Notice 12/8/04—published 2/2/05, effective 2/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 6/17/05 after Notice 8/4/04—published 7/6/05, effective 7/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed emergency 7/15/05 after Notice 5/11/05—published 8/3/05, effective 8/1/05]
[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
[Filed emergency 1/12/06 after Notice 11/23/05—published 2/1/06, effective 2/1/06]
[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
[Filed without Notice 4/17/06—published 5/10/06, effective 7/1/06]
[Filed emergency 5/12/06—published 6/7/06, effective 6/1/06]
[Filed emergency 6/16/06 after Notice 4/12/06—published 7/5/06, effective 7/1/06]
[Filed emergency 6/16/06 after Notice 5/10/06—published 7/5/06, effective 7/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]◊
[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]
[Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
[Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
[Filed 12/13/06, Notice 7/5/06—published 1/3/07, effective 2/7/07]
[Filed 4/11/07, Notice 2/28/07—published 5/9/07, effective 7/1/07]
[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]◊
[Filed emergency 6/15/07—published 7/4/07, effective 7/1/07]◊
[Filed emergency 6/13/07—published 7/4/07, effective 8/1/07]
[Filed emergency 7/12/07 after Notice 5/9/07—published 8/1/07, effective 8/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]◊

[Filed emergency 10/10/07 after Notice 8/29/07—published 11/7/07, effective 11/1/07]
[Filed 12/12/07, Notice 7/4/07—published 1/2/08, effective 2/6/08]◊
[Filed emergency 1/9/08 after Notice 12/5/07—published 1/30/08, effective 2/1/08]
[Filed emergency 2/13/08 after Notice 12/19/07—published 3/12/08, effective 2/15/08]
[Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
[Filed 4/10/08, Notice 1/30/08—published 5/7/08, effective 7/1/08]
[Filed 4/10/08, Notice 2/27/08—published 5/7/08, effective 7/1/08]
[Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]◊
[Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]

◊ Two or more ARCs

1 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Pharmacies are eligible to participate providing they are licensed in the state of Iowa or duly licensed in other states.

441—77.3(249A) Hospitals. All hospitals licensed in the state of Iowa and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program. Hospitals in other states are also eligible if duly licensed and certified for Medicare participation in that state.

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid recipients to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety's name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. Effective dates and submission dates.

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. Amount of bond. Bonds for any period shall be in the amount of $50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of $50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. Other requirements. Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Remedial services providers. A provider of remedial services is eligible to participate in the medical assistance program when:

1. The provider is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission pursuant to 441—Chapter 24; or

2. The provider is certified by the department as a provider of rehabilitative treatment services pursuant to 441—185.10(234) as of August 31, 2006; or

3. The provider can demonstrate to the Iowa Medicaid enterprise that the provider has the skills and resources necessary to implement a member's treatment plan and remedial services implementation plan.

This rule is intended to implement Iowa Code section 249A.4 and 2006 Iowa Acts, House File 2734, section 10, subsection 11.

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic

Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) *Definitions.*

"Guardian" means a guardian appointed in probate or juvenile court.

"Incident" means an occurrence involving a member that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in someone's death;
3. Requires emergency intervention or mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or
6. Constitutes any prescription medication error.

77.25(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) *Incident reporting.* The provider shall document incidents and shall make the incident reports and related documentation available to the department upon request. The provider shall ensure cooperation in providing pertinent information regarding incidents as requested by the department.

a. Report form. Each incident shall be recorded on an incident report form that is completed and signed by the staff person who was directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

(1) The name of the member involved.

(2) The date and time the incident occurred.

(3) A description of the incident.

(4) The names of all provider staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other members who are involved in the incident must be maintained by the use of initials or other means.

(5) The action that the staff took to handle the incident.

(6) The resolution of or follow-up to the incident.

b. Reporting procedure for incidents. When an incident occurs, provider staff shall notify the member or the member's legal guardian within 72 hours of the incident and shall distribute the completed incident report form as follows:

(1) Forward the report to the supervisor within 24 hours of the incident.

(2) Send a copy of the report to the member's Medicaid targeted case manager and the department's bureau of long-term care within 72 hours of the incident.

(3) File a copy of the report in a centralized location and make a notation in the member's file.

77.25(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) *Case management.* The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

77.25(6) *Day habilitation.* The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a," "d," "g,"* or *"h."*

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(7) *Home-based habilitation.* The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(8) *Prevocational habilitation.* The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

77.25(9) *Supported employment habilitation.* The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

77.25(10) *Provider enrollment.* A prospective provider that meets the criteria in this rule shall be enrolled as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. Payment for services will be made to a provider only upon department approval of the provider and of the service the provider is authorized to provide.

a. The Iowa Medicaid enterprise shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

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

441—77.26(249A) Nurse-midwives. Rescinded IAB 10/15/03, effective 12/1/03.

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) *Standards in 441—Chapter 24.* Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) *Standards in 441—Chapter 186.* Rescinded IAB 10/12/05, effective 10/1/05.

441—77.30(249A) HCBS ill and handicapped waiver service providers. HCBS ill and handicapped waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS ill and handicapped waiver program if they meet the standards set forth below:

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

77.30(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.30(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the HCBS MR or BI waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

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

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

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

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

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

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

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

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

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

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

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

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

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

(1) Be at least 18 years of age.

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

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

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

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 321—4.4(231).

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

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

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

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

d. Restaurants licensed and inspected under Iowa Code chapter 137B.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a licensed dietitian:

a. Hospitals enrolled as Medicaid providers.

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

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

d. Home health agencies certified by Medicare.

e. Licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the consumer's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the consumer.

d. The broker shall not work for an individual or entity that is providing services to the consumer.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the consumer.

f. The broker must complete an independent support brokerage certification approved by the department.

77.30(15) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age; and

(2) Be able to communicate successfully with the consumer.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

77.30(16) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age; and

(2) Be able to communicate successfully with the consumer.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

77.30(17) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age; and

(2) Be able to communicate successfully with the consumer.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

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

441—77.31(249A) Nurse anesthetists. Rescinded IAB 10/15/03, effective 12/1/03.

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards set forth below:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the HCBS MR waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Area agencies on aging as designated in 321—4.4(231). Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide chore services may also provide chore services.

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

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

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

e. Providers certified under the HCBS MR waiver.

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

a. Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

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

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

d. Restaurants licensed and inspected under Iowa Code chapter 137B.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 321—4.4(231).

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

c. Providers eligible to participate as home and vehicle modification provides under the ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 321—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

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

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

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

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

a. Hospitals enrolled as Medicaid providers.

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

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

d. Home health agencies certified by Medicare.

e. Licensed dietitians approved by an area agency on aging.

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

a. Medicaid-eligible medical equipment and supply dealers.

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

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

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer.

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

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

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

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

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

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

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider organization shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (The Council) to provide case management; or

(5) Is approved by the department of elder affairs as meeting the standards for case management services in 321—Chapter 21; or

(6) Is approved by the department of public health as meeting the standards for case management services in 641—Chapter 80.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1) Specific procedures to identify conflicts of interest.

(2) Procedures to eliminate any conflict of interest that is identified.

(3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

(1) That entity must also meet the provider qualifications in this subrule; and

(2) The contractor is responsible for verification of compliance.

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

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards set forth below:

77.34(1) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135) and 641—80.7(135), or which are certified as a home health agency under Medicare.

77.34(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the HCBS MR or BI waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

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

e. Restaurants licensed and inspected under Iowa Code chapter 137B.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

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

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

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

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

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

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

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

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

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

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) HCBS MR waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS mental retardation waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)*"a"*(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS MR providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.
(2) Confidentiality.
(3) Provision of consumer medication.
(4) Identification and reporting of child and dependent adult abuse.
(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.
(2) Gathers information from consumers, family members, and staff.
(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
(5) Identifies areas in need of improvement.
(6) Develops a plan to address the areas in need of improvement.
(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.
b. (Outcome 3) Consumers live in positive environments.
c. (Outcome 4) Consumers work in positive environments.
d. (Outcome 5) Consumers exercise their rights and responsibilities.
e. (Outcome 6) Consumers have privacy.
f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
g. (Outcome 8) Consumers decide which personal information is shared and with whom.
h. (Outcome 9) Consumers make informed choices about where they work.
i. (Outcome 10) Consumers make informed choices on how they spend their free time.
j. (Outcome 11) Consumers make informed choices about where and with whom they live.
k. (Outcome 12) Consumers choose their daily routine.
l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
m. (Outcome 14) Consumers have a social network and varied relationships.
n. (Outcome 15) Consumers develop and accomplish personal goals.
o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
p. (Outcome 17) Consumers maintain good health.
q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident reporting.* The provider shall document major and minor incidents and make the incident reports and related documentation available to the department upon request. The provider shall ensure cooperation in providing pertinent information regarding incidents as requested by the department.

a. Major incident defined. A "major incident" means an occurrence involving a consumer of services that:

(1) Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

(2) Results in someone's death;

(3) Requires emergency mental health treatment for the consumer;

(4) Requires the intervention of law enforcement;

(5) Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or

(6) Constitutes a prescription medication error or a pattern of medication errors that could lead to the outcome in subparagraph (1), (2), or (3).

b. Minor incident defined. A "minor incident" means an occurrence involving a consumer of services that is not a major incident and that:

(1) Results in the application of basic first aid;

(2) Results in bruising;

(3) Results in seizure activity;

(4) Results in injury to self, to others, or to property; or

(5) Constitutes a prescription medication error.

c. Report form. Each major or minor incident shall be recorded on an incident report form that is completed and signed by the staff who were directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

(1) The name of the consumer involved.

(2) The date and time the incident occurred.

(3) A description of the incident.

(4) The names of all provider staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other consumers who are involved in the incident must be maintained by the use of initials or other means.

(5) The action that the staff took to handle the incident.

(6) The resolution of or follow-up to the incident.

d. Reporting procedure for major incidents. When a major incident occurs, provider staff shall notify the consumer or the consumer's legal guardian within 72 hours of the incident and shall distribute the completed incident report form as follows:

(1) Forward the report to the supervisor within 24 hours of the incident.

(2) Send a copy of the report to the consumer's Medicaid targeted case manager and the department's bureau of long-term care within 72 hours of the incident.

(3) File a copy of the report in a centralized location and make a notation in the consumer's file.

e. Reporting procedure for minor incidents. When a minor incident occurs, provider staff shall distribute the completed incident report form as follows:

(1) Forward the report to the supervisor within 24 hours of the incident.

(2) File a copy of the report in a centralized location and make a notation in the consumer's file.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

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

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present

for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS MR waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) *Review of providers.* Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)*"e"* and 77.37 (13)*"f."*

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) *Supported community living providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. Living units designed to serve more than three supported community living consumers shall be approved as follows:

(1) The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.

(2) The department may approve conversion of a total of 40 living units for five persons or fewer formerly licensed as residential care facilities for persons with mental retardation to living units designed to serve supported community living consumers. Upon approval, the living unit shall surrender the facility license and continue to operate under the medical assistance home- and community-based services waiver for persons with mental retardation.

Approvals of living units for five persons or fewer formerly licensed as residential care facilities for persons with mental retardation granted before July 1, 2002, shall remain in effect.

Applications for approval to be granted under this subparagraph after July 1, 2003, shall be submitted to the Department of Human Services, Bureau of Long-Term Care, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The application shall include a letter of support from the county in which the living unit is located. The letter shall verify that the county will request sufficient waiver slots for the consumers to be served and provide necessary county funding.

The bureau of long-term care shall approve the application based on the letter of support from the county and the requirement to maintain the geographical distribution of supported community living programs to avoid an overconcentration of programs in an area.

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

(4) The department shall approve a living unit for five persons subject to all of the following conditions:

1. Approval will not result in an overconcentration of such living units in an area.

2. The county in which the living unit is located submits a letter of support for approval to the bureau of long-term care.

3. The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following:

- The quantity of services currently available in the county is insufficient to meet the need.
- The quantity of affordable rental housing in the county is insufficient.
- Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

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

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

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

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

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

(1) Consumer vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

(5) Department of labor requirements.

b. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.37(17) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the mental retardation or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

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

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

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

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

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

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

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

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

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

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

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

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

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

(1) Be at least 18 years of age.

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

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

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

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues.Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
4. Specific service activities to be provided to achieve the objectives.
5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
6. Date of service initiation and date of individual service plan development.
7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.
2. Progress toward goals and objectives is not being made.
3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h"* and subparagraph 77.37(23)*"f"*(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

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

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 321—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

b. The Council on Quality and Leadership.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a"* or *"d."*

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

441—77.38(249A) Rehabilitative treatment service providers. Rescinded IAB 8/1/07, effective 9/5/07.

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to

the individual service. Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.
b. (Outcome 3) Consumers live in positive environments.
c. (Outcome 4) Consumers work in positive environments.
d. (Outcome 5) Consumers exercise their rights and responsibilities.
e. (Outcome 6) Consumers have privacy.
f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
g. (Outcome 8) Consumers decide which personal information is shared and with whom.
h. (Outcome 9) Consumers make informed choices about where they work.
i. (Outcome 10) Consumers make informed choices on how they spend their free time.
j. (Outcome 11) Consumers make informed choices about where and with whom they live.
k. (Outcome 12) Consumers choose their daily routine.
l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
m. (Outcome 14) Consumers have a social network and varied relationships.
n. (Outcome 15) Consumers develop and accomplish personal goals.
o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
p. (Outcome 17) Consumers maintain good health.
q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Reporting requirements.*

a. Abuse reporting. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

b. Incident reporting. The provider shall document major and minor incidents and make the incident reports and related documentation available to the department upon request. The provider shall ensure cooperation in providing pertinent information regarding incidents as requested by the department.

(1) Major incident defined. A "major incident" means an occurrence involving a consumer of services that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in someone's death;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or
6. Constitutes a prescription medication error or a pattern of medication errors that could lead to the outcome in numbered paragraph "1," "2," or "3."

(2) Minor incident defined. A "minor incident" means an occurrence involving a consumer of services that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(3) Report form. Each major or minor incident shall be recorded on an incident report form that is completed and signed by the staff who were directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other consumers who are involved in the incident must be maintained by the use of initials or other means.
5. The action that the staff took to handle the incident.
6. The resolution of or follow-up to the incident.

(4) Reporting procedure for major incidents. When a major incident occurs, provider staff shall notify the consumer or the consumer's legal guardian within 72 hours of the incident and shall distribute the completed incident report form as follows:

1. Forward the report to the supervisor within 24 hours of the incident.
2. Send a copy of the report to the consumer's Medicaid targeted case manager and the department's bureau of long-term care within 72 hours of the incident.
3. File a copy of the report in a centralized location and make a notation in the consumer's file.

(5) Reporting procedure for minor incidents. When a minor incident occurs, provider staff shall distribute the completed incident report form as follows:

1. Forward the report to the supervisor within 24 hours of the incident.
2. File a copy of the report in a centralized location and make a notation in the consumer's file.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

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

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall

require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)*"f."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in

441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

[1] *e.* Living units designed to serve more than three supported community living consumers shall be approved as follows:

(1) The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.

(2) The department may approve living units designed to serve more than four supported community living consumers under an exception to policy pursuant to rule 441—1.8(17A,217), subject to the following additional requirements:

1. The provider shall provide verification from the department of inspections and appeals that the program is not required to be licensed as a health care facility under Iowa Code chapter 135C.

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

3. The geographic location of the program shall not result in an overconcentration of supported community living programs in the area.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS mental retardation waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(11) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

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

(1) Consumer vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

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

b. The department shall certify only public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 321—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

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

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

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

77.39(19) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

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

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) *Prevocational services providers.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

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

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

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

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

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

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

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

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

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

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

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

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

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

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

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

(1) Be at least 18 years of age.

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

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

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

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[1] Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

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

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

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

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

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

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

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

77.41(3) *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) *Transportation service providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 321—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

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

c. Regional transit agencies as recognized by the Iowa department of transportation.

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

77.41(7) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

441—77.42(249A) Rehabilitation services to adults with chronic mental illness providers. Rescinded IAB 8/1/07, effective 9/5/07.

441—77.43(249A) Infant and toddler program providers. A public agency provider in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA) is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the following additional requirements are met.

77.43(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards:

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. Incident reporting. The provider shall document major and minor incidents and make the incident reports and related documentation available to the department upon request. The provider shall ensure cooperation in providing pertinent information regarding incidents as requested by the department.

(1) Major incident defined. A "major incident" means an occurrence involving a consumer that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in a consumer's death or the death of another person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69; or
6. Constitutes a prescription medication error or a pattern of medication errors that could lead to the outcome in numbered paragraph "1," "2," or "3."

(2) Minor incident defined. A "minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(3) Report form. Each major or minor incident occurring during service provision shall be recorded on an incident report form. The form shall be completed and signed by the provider staff who were directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident, including designation of the incident as a major or minor incident.
4. The names of all provider staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were involved in the incident must be maintained by the use of initials or other means.
5. The action that the staff took to manage the incident.
6. The resolution of or follow-up to the incident.

(4) Reporting procedure for major incidents. When a major incident occurs or when staff becomes aware of a major incident, the procedure shall be as follows:

1. Provider staff shall notify the supervisor immediately.
2. The supervisor shall immediately notify the consumer's case manager and the consumer's parents or legal guardian, unless the parent or legal guardian is suspected as the perpetrator. If a parent or legal guardian is suspected as the perpetrator, the supervisor shall follow the procedure for reporting child abuse according to Iowa Code section 232.69.
3. Provider staff shall complete the incident report and forward the report to the supervisor within 24 hours of the incident.
4. Within 72 hours of the incident, the supervisor shall send a copy of the incident report to the consumer's case manager, the department's quality assurance staff, and the consumer's parents or legal guardian.
5. The provider shall file a copy of the incident report in a centralized location and make a notation in the consumer's case file.

(5) Reporting procedure for minor incidents. When a minor incident occurs:

1. Provider staff shall notify the consumer's parents or legal guardian immediately.

2. Provider staff shall complete an incident report and submit the report to the supervisor within 24 hours of the minor incident.

3. Provider staff shall make a notation in the consumer's case file.

4. The supervisor shall file the incident report in a centralized location.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS mental retardation or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. Qualified providers. The following agencies may provide family and community support services under the children's mental health waiver:

(1) Rehabilitative treatment services skill development providers certified in good standing under 441—185.10(234).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) *In-home family therapy providers.*

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Rehabilitative treatment services therapy and counseling providers certified in good standing under 441—185.10(234).

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) *Respite care providers.*

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Child care centers licensed in good standing by the department according to 441—Chapter 109 and child development homes registered according to 441—Chapter 110.

(4) Camps certified in good standing by the American Camping Association.

(5) Home health agencies that are certified in good standing to participate in the Medicare program.

(6) Home care agencies that meet the requirements set forth in department of public health rule 641—80.7(135).

(7) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

(8) Assisted living programs certified in good standing by the department of inspections and appeals.

(9) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(10) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)*"c."*

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[Filed 3/11/70, amended 6/21/73, 2/13/75, 3/21/75]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 2/8/78, Notice 12/28/78—published 3/8/78, effective 4/12/78]
[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]
[Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]

[Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]
[Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notice 11/14/90—published 2/6/91, effective 4/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 6/14/91, Notice 5/1/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]
[Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/5/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed 11/16/95, Notices 8/2/95, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 10/9/96, Notice 8/14/96—published 11/6/96, effective 1/1/97]
[Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
[Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed emergency 9/13/99—published 10/6/99, effective 10/1/99]
[Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]◊
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]◊
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]

[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/15/02][1]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◊
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]

◊ Two or more ARCs

1 December 15, 2002, effective date of 77.37(14)*"e"*(2) and 77.39(13)*"e"* delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

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

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

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

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

78.1(1) Payment will not be made for:

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

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

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

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

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

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

e. All physicians who administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. Vaccines available through the vaccines

for children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

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

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

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

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

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

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

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

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

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

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

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

(1) Correction of a congenital anomaly; or

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

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

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

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

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

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

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

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

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

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

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

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

(3) Augmentation mammoplasties.

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

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

(6) Panniculectomy and body sculpture procedures.

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

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

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

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

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Sets work standards.

(3) Establishes job description.

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

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

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

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

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

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

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days prior to the expected delivery date for premature deliveries. Consent shall be obtained on Form 470-0835 or 470-0835(S), Consent Form, and shall be attached to the claim for payment.

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

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

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

(1) In labor or childbirth, or

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

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

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

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

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

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

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

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

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

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report

shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

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

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

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

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

78.1(20) Transplants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.1(22) Risk assessments. Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid member's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include care coordination, health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Payment for EPSDT care coordination services outlined in 78.18(6)*"b"*(2)"1" to "7" is available to MediPASS eligible providers as defined in rule 441—88.41(249A) who accept responsibility for providing EPSDT care coordination services to the MediPASS members under the age of 21 assigned to them on a monthly basis. All MediPASS providers shall be required to complete Form 470-3183, Care Coordination Agreement, to reflect acceptance or denial of EPSDT care coordination responsibility. When the MediPASS provider does not accept the responsibility, the MediPASS members assigned to the MediPASS provider are automatically referred to the designated department of public health EPSDT care coordination agency in the member's geographical area. Acknowledgment of acceptance of the EPSDT care coordination responsibility shall be for a specified period of time of no less than six months. MediPASS providers who identify MediPASS EPSDT members in need of transportation assistance beyond that available according to rule 441—78.13(249A) shall be referred to the designated department of public health agency assigned to the geographical area of the member's residence.

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

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

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

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

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

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

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

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

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

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

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

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

b. Payment is not made for:

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

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

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

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

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

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

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

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

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

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

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

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg

Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion, wash
Calcium carbonate chewable tablets 1250 mg (500 mg elemental calcium)
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Ferrous sulfate tablets 300 mg, 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 300 mg, 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization
Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 25 mg, 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Omeprazole magnesium delayed-release tablets 20 mg (base equivalent)
Pediatric oral electrolyte solutions
Permethrin liquid 1%
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
Pseudoephedrine/dextromethorphan 15 mg/5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution
Pyrethrins-piperonyl butoxide liquid 0.33-4%

Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides granules 15 mg/5 ml
Sennosides tablets 187 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Sodium chloride solution 0.9% for inhalation with metered dispensing valve 90 ml, 240 ml
Tolnaftate 1% cream, solution, powder
Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Recipient selection and education.

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

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

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

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

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

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

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

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

The team should consist of:

A surgeon director.

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

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

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

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

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

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

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

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

Legal counsel familiar with transplantation laws and regulations.

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

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

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

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

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to

be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

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

78.3(16) Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct

care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

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

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

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

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

d. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per patient in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than

stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when recipients are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2)*"e"*)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Gingivoplasty will be paid per tooth.

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

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

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

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

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

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

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

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

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

a. Extractions, both surgical and nonsurgical.

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

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

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

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

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

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

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

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

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

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

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

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

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure

and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

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

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for recipients whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the recipient is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(2))

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.4(14) *Services to adults 21 years of age and older.* Effective May 10, 2002, the following dental services are not covered for adults 21 years of age and older:

a. Crowns, posts, and cores on anterior teeth that have not received endodontic treatment and on posterior teeth.

b. Periodontal services.

c. Endodontic services on posterior teeth.

d. Orthodontic procedures.

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

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

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

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

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

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

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

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

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

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

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking

the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

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

78.5(3) Prescriptions are required for drugs and supplies as specified in rule 78.1(2)*"c."* Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

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

78.6(1) *Payable professional services are:*

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

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

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

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

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

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

(2) Gonioscopy.

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

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

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation.

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

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

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

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

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

(3) Protective lenses are allowed for:

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

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

f. Frame service.

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

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

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

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

(3) Safety frames are allowed for:

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

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

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

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

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

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

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

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

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice.

a. Materials payable by fee schedule are:

(1) Lenses, single vision and multifocal.
(2) Frames.
(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.
(2) Schroeder shield.
(3) Ptosis crutch.

(4) Protective lenses and safety frames.

(5) Subnormal visual aids.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for recipients eight years of age and older. Approval shall be given when the recipient's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

78.6(6) *Therapeutically certified optometrists.* Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry examiners to employ the agents and perform the procedures provided by the Iowa Code.

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

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1)to **78.7(3)**Rescinded IAB 4/3/02, effective 6/1/02.

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

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		
		724.6	Disorders of sacrum, ankylosis		
		724.79	Disorders of coccyx, coccygodynia		
		724.8	Other symptoms referable to back, facet syndrome		
		729.1	Myalgia and myositis, unspecified		
		729.4	Fascitis, unspecified		
		738.40	Acquired spondylolisthesis		
		756.12	Spondylolisthesis		

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

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

c. CMT is not a covered benefit when:

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

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

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

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

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

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

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one

per condition, consistent with the provisions of paragraph *"a"* of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph *"a"* of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

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

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the recipient that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The recipient need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the recipient's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the recipient's residence when medically necessary.

Medicaid recipients of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a recipient.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the recipient's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of recipient in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of recipient in response to treatment.
g. Medical supplies to be furnished.
h. Recipient's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.

(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 62 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's signature and date. The date of the signature shall be within the certification period.

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

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the recipient or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The recipient requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the recipient in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the recipient's institutionalization when the primary need of the recipient for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the recipient, e.g., lives alone or with family.

78.9(8) *Medical social services.*

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

(1) Are reasonable and necessary to the treatment of a recipient's illness or injury.

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

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the recipient's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the recipient and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the recipients are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

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

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

a. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

b. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

c. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

d. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the recipient's physician to a recipient in the recipient's place of residence or outside the recipient's residence, when normal life activities take the recipient outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the recipient. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other members of the recipient's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the recipient's physician to a recipient in the recipient's place of residence or outside the recipient's residence, when normal life activities take the recipient outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the recipient's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the recipient requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the recipient's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the recipient whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or

months of service per discipline. If the recipient is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) *Vaccines.* Home health agencies which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Home health agencies may provide vaccines for children clinics and be reimbursed for vaccine administration to provide vaccines for children program vaccines to Medicaid children in other than the home setting.

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

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions, or is primarily for the convenience of a person caring for the patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise, and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 150 percent of the purchase price. At the point that total rent paid equals 150 percent of the purchase allowance, the recipient will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators will be maintained on a rental basis for the duration of use.

g. Payment may be made for necessary repair, maintenance, and supplies for recipient-owned equipment. No payment may be made for repairs, maintenance, or supplies when the recipient is renting the item.

h. Replacement of recipient-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the patient's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

78.10(2) *Durable medical equipment.* DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment will not be provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded except when a Medicaid-eligible resident of a nursing facility medically needs oxygen for 12 or more hours per day for at least 30 days or more. Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that a resident of a nursing facility requires oxygen for 12 hours or more per day and the provider and physician, physician assistant, or advanced registered nurse practitioner jointly submit Certificate of Medical Necessity, Form CMS-484, from Medicare or a reasonable facsimile to the Iowa Medicaid enterprise with the monthly billing. The documentation submitted must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.

Automated medication dispenser. See 78.10(2)*"d"* for prior authorization requirements.

Bedpan.

Blood pressure cuffs.

Cane.

Cardiorespiratory monitor (rental and supplies).

Commode.

Commode pail.

Crutches.

Decubitus equipment.

Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2)*"d"* for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for recipients five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2)*"d"* for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2)*"d"* for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for recipients with significant hypoxemia, as shown by medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription shall document that other forms of treatment have been tried and have not been successful, and that oxygen therapy is required.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician's Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Recipients may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

(5) All accessories, disposable supplies, servicing, and repairing of concentrators are included in the monthly Medicaid payment for concentrators.

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.
2. The patient's mobility puts the patient at risk for injury.
3. The patient has suffered injuries when getting out of bed.
4. The patient has had a successful trial with an enclosed bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient with a diagnosis of a lung disorder if all of the following conditions are met:

1. Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease of lung function.
2. The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.
3. Treatment by flutter device failed or is contraindicated.
4. Treatment by intrapulmonary percussive ventilation failed or is contraindicated.
5. All other less costly alternatives have been tried.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.
2. The member is on two or more medications prescribed to be administered more than one time a day.
3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.
4. Less costly alternatives, such as medisets or telephone reminders, have failed.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a patient prior to the time the patient undergoes a procedure which will make necessary the use of the device.

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

Artificial eyes.

Artificial limbs.

Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3)*"c"* for prior approval requirements.

Enteral delivery supplies and products. See 78.10(3)*"c"* for prior approval requirements.

Hearing aids. See rule 441—78.14(249A).

Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements.

Orthotic devices. See 78.10(3)*"d"* for limitations on coverage of cranial orthotic devices.

Ostomy appliances.

Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

Prosthetic shoes. See rule 441—78.15(249A).

Tracheotomy tubes.

Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(8))

c. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered

nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1)*"c"*)

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a recipient who either has a metabolic or digestive disorder that prevents the recipient from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the recipient's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

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

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

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the recipient is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the recipient.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

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

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

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the recipient.

Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the recipient is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is between 6 and 18 months of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or
2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. Medical supplies are not to be dispensed at any one time for quantities exceeding a three-month supply. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

Catheter (indwelling Foley).
Colostomy and ileostomy appliances.
Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
Diabetic supplies (needles and syringes, blood glucose test strips and diabetic urine test supplies).
Dialysis supplies.
Diapers (for recipients aged four and above).
Disposable catheterization trays or sets (sterile).
Disposable irrigation trays or sets (sterile).
Disposable saline enemas (e.g., sodium phosphate type).
Disposable underpads.
Dressings.
Elastic antiembolism support stocking.
Enema.
Hearing aid batteries.
Respirator supplies.
Surgical supplies.
Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).
Colostomy and ileostomy appliances.
Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.
Diabetic supplies (needles and syringes, blood glucose test strips and diabetic urine test supplies).
Disposable catheterization trays or sets (sterile).
Disposable irrigation trays or sets (sterile).
Disposable saline enemas (e.g., sodium phosphate type).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution

with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) *Covered services.* Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

(5) Community psychiatric supportive treatment is not intended to be provided in a group.

b. Crisis intervention to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

c. Health or behavior intervention, used to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.

(2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.

d. Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.

e. Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.

(1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Skills training and development services are covered only for Medicaid members aged 18 or over.

78.12(2) *Excluded services.* Services that are habilitative in nature are not covered as remedial services. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

78.12(3) *Coverage requirements.* Medicaid covers remedial services only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:

(1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and

(2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).

b. The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441— Chapter 88, Division IV.

c. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) *Approval of plan.* The remedial services provider shall submit the treatment plan and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial plan. The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

(5) The plan does not exceed six months' duration; and

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. Subsequent plans. The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph *"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress.

c. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

(1) The time elapsed from referral to remedial plan development;

(2) The continuity of treatment;

(3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;

(4) Gaps in service;

(5) The results achieved; and

(6) Member satisfaction.

78.12(5) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of remedial services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2006 Iowa Acts, House File 2734, section 10, subsection 11.

441—78.13(249A) Transportation to receive medical care. Payment will be approved for transportation to receive services covered under the program, including transportation to obtain prescribed drugs, when all of the following conditions are met.

78.13(1) Transportation costs are reimbursable only when:

a. The source of the care is located outside the city limits of the community in which the member resides; or

b. The member resides in a rural area and must travel to a city to receive necessary care.

78.13(2) Transportation costs are reimbursable only when:

a. The type of care is not available in the community in which the member resides; or

b. The member has been referred by the attending physician to a specialist in another community.

78.13(3) Transportation costs are reimbursable only when there is no resource available to the member through which necessary transportation might be secured free of charge. EXCEPTION: Costs of transportation to obtain prescribed drugs may be reimbursed irrespective of whether free delivery is offered when the prescription drug is needed immediately.

78.13(4) Transportation is reimbursable only to the nearest institution or practitioner having appropriate facilities for the care of the member.

78.13(5) Transportation may be of any type and may be provided from any source.

a. Effective November 1, 2005, when transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of 30 cents per mile.

b. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed the charge that would be made by the most economical available source of public transportation.

c. In all cases where public transportation is reasonably available to or from the source of care and the member's condition does not preclude its use, public transportation must be utilized. When the member's condition precludes the use of public transportation, a statement to the effect shall be included in the case record.

78.13(6) In the case of a child too young to travel alone, or an adult or child who because of physical or mental incapacity is unable to travel alone, payment subject to the above conditions shall be made for the transportation costs of an escort. The worker is responsible for making a decision concerning the necessity of an escort and recording the basis for the decision in the case record.

78.13(7) When meals and lodging or other travel expenses are required in connection with transportation, payment will be subject to the same conditions as for a state employee and the maximum amount payable shall not exceed the maximum payable to a state employee for the same expenses in connection with official travel within the state of Iowa.

78.13(8) When the services of an escort are required subject to the conditions in subrule 78.13(6), payment may be made for the escort's meals and lodging, when required, on the same basis as for the member.

78.13(9) Payment will not be made in advance to a member or a provider of medical transportation.

78.13(10) Payment for transportation to receive medical care is made to the member with the following exceptions:

a. Payment may be made to the agency that provided transportation if the agency is certified by the department of transportation and requests direct payment. Reimbursement for transportation shall be based on a fee schedule by mile or by trip.

b. In cases where the local office has established that the member has persistently failed to reimburse a provider of medical transportation, payment may be made directly to the provider.

c. In all situations where one of the department's volunteers is the provider of transportation.

78.13(11) Form 470-0386, Medical Transportation Claim, shall be completed by the member and the medical provider and submitted to the local office for each trip for which payment is requested. All trips to the same provider in a calendar month may, at the member's option, be submitted on the same form.

78.13(12) No claim shall be paid if presented after the lapse of 365 days from its accrual unless it is to correct payment on a claim originally submitted within the required period.

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

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The recipient shall have an examination by a physician to determine that the recipient has no condition which would contraindicate the use of a hearing aid. This report shall be made on Form 470-0361, Section A, Report of Examination for a Hearing Aid. The requirement for a physician evaluation shall be waived for recipients 18 years of age and older when the recipient has signed an informed consent statement acknowledging that the recipient:

a. Has been advised that it may be in the recipient's best health interest to receive a medical evaluation from a licensed physician prior to purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a recipient could benefit from the use of a hearing aid. The audiologist shall report audiological testing on Form 470-0361, Section B. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a recipient could benefit from a hearing aid. The physician or audiologist shall report the hearing aid evaluation on Form 470-0828, Hearing Aid Evaluation/Selection Report. When a hearing aid is recommended for a recipient, the physician or audiologist recommending the hearing aid shall see the recipient at least one time within 30 days subsequent to purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the recipient's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model

appropriate to the recipient's condition. The physician, audiologists or hearing aid dispenser shall report the hearing aid selection on Form 470-0828, Hearing Aid Evaluation/Selection Report.

78.14(5) *Travel.* When a recipient is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the recipient's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall make payment for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall make payment for binaural amplification when:

a. A child needs the aid for speech development, or

b. The aid is needed for educational or vocational purposes, or

c. The aid is for a blind individual.

Payment for binaural amplification shall also be approved where the recipient's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or where lack of binaural amplification poses a hazard to a recipient's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval.

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the recipient is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4)*"b"*):

1. Educational purposes when the recipient is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;

2. Is made of leather or another suitable material of equal quality;

3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and

4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.
(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to medical assistance recipients by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board eligible or board certified psychiatrist. All services must be performed under the supervision of a board eligible or board certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member, listed in this subrule, performing the preliminary diagnostic evaluation of medical assistance recipients for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist,

then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed

by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in subrule 84.1(1) for individuals under 21 years of age who are eligible for medical assistance.

78.18(1) Screening centers which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid recipients.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Payment will be approved for early and periodic screening, diagnosis and treatment (EPSDT) targeted case management services (hereinafter referred to as EPSDT information and care coordination) for persons under age 21.

EXCEPTION: Payment will not be approved for persons under age 21 who are medically needy recipients as defined at 441—subrule 75.1(35) who are subject to spenddown, or enrolled in a health maintenance organization or foster care.

a. Information and care coordination services shall be provided by a registered nurse or persons with at least a bachelor's degree in health education, social work, counseling, sociology, or psychology. A licensed practical nurse or a paraprofessional may provide the service if the licensed practical nurse or paraprofessional works under the direct supervision of a health professional, such as a registered nurse or person with at least a bachelor's degree in health education, social work, counseling, sociology, or psychology. Payment for information services shall be provided only to designated department of public health agencies.

b. EPSDT information and care coordination services are as follows:

(1) Information activities which are face-to-face visits (including home visits), telephone contacts or written correspondence made for the purpose of promoting preventive health care. Information activities shall be provided to guardians or custodians within 60 days of a determination of Medicaid eligibility for persons under age 21. Activities shall utilize accepted methods for informing guardians or custodians who are illiterate, blind, deaf, or cannot understand the English language. Information activities include:

1. An explanation of the benefits of preventive health care and EPSDT information and care coordination services.
2. A description of services provided in periodic exams.
3. A summary of the periodicity schedule.
4. Information on how EPSDT services can be obtained.
5. Information on the available health resources in the community.
6. Information about other programs which may be of assistance such as head start, child health specialty clinics, women, infants and children (WIC) services, local and area education agencies, local parenting programs, mental health services and social service agencies.
7. A determination of whether the eligible child or youth's legal guardian, and in some cases custodian, wants to participate in care coordination services. At a minimum if the guardian or custodian chooses not to receive the initial screen, the care coordinator will document the decision and recontact the guardian or custodian in a year. If there are children under the age of two, the care coordinator will document the decision and recontact the guardian or custodian within six months if the first decision is not to receive the initial screen.

(2) Care coordination services are defined as ongoing activities which can be face-to-face visits (including home visits), telephone contacts or written correspondence which ensure that EPSDT services are received by children and youth participating in the EPSDT program. Ongoing activities include:

1. Providing the assistance needed to receive early and periodic screenings, and diagnostic and treatment services. Assistance may include, but is not limited to, explaining the necessity for the service, locating needed health care services, scheduling an appointment, arranging transportation, or child care. Arranging transportation or child care does not mean the care coordinator has to transport the recipient or pay for transportation or provide or pay for child care.
2. Authorizing transportation not covered under rule 441—78.13(249A). Payment will be approved for in-town transportation authorized by the EPSDT care coordinator for EPSDT screens, follow-up diagnosis, or treatment services which are not eligible for payment under rule 441—78.13(249A).
3. Establishing and maintaining community linkages with other preventive health care providers in the community such as dentists, primary care physicians, child health centers, WIC, head start, child health specialty clinics, and local and area education agencies must be included in care coordination services.
4. Monitoring to determine that screening and medically necessary diagnostic and treatment services have been received.

5. Maintaining documentation of the care coordination services, including all contacts with and on behalf of recipients; date of care coordination service; name of agency providing care coordination; staff person providing the service; nature, extent, or units of service; and place of service delivery.

6. Notifying the guardian or custodian when the next screening is due.

7. Providing ongoing information about other programs which may be of assistance such as head start; child health specialty clinics; women, infants and children (WIC) services; local and area education agencies; local parenting programs; mental health services and social service agencies.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

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

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the recipient's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).[1]

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)
2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B),* and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories

of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

(5) The date of the start of the services.

(6) The frequency of the services.

(7) Progress in response to the services.

(8) The estimated length of time the services are needed.

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

[1] Proposed rule 645—201.6(272C), ARC 0990B, IAB 10/3/01.

[2] Proposed rule 645—206.6(272C), ARC 0989B, IAB 10/3/01.

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

78.21(2) *Risk assessments.* Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. See description of enhanced services at subrule 78.25(3).

Rural health clinics which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients.

78.21(3) *EPSDT care coordination.* Payment for EPSDT care coordination services outlined in 78.18(6)*"b"*(2)"1" to "7" is available to MediPASS eligible providers as defined in rule 441—88.41(249A) who accept responsibility for providing EPSDT care coordination services to the MediPASS recipients under the age of 21 assigned to them on a monthly basis. All MediPASS providers shall be required to complete Form 470-3183, Care Coordination Agreement, to reflect acceptance or denial of EPSDT care coordination responsibility. When the MediPASS provider does not accept the responsibility, the MediPASS patients assigned to the MediPASS provider are automatically referred to the designated department of public health EPSDT care coordination agency in the recipient's geographical area. Acknowledgment of acceptance of the EPSDT care coordination responsibility shall be for a specified period of time of no less than six months. MediPASS providers who identify MediPASS EPSDT recipients in need of transportation assistance beyond that available according to rule 441—78.13(249A) shall be referred to the designated department of public health agency assigned to the geographical area of the recipient's residence.

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

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics. Payment will be made for sterilization in accordance with 78.1(16). Family planning clinics which wish to administer vaccines for Medicaid recipients who receive family planning services at the family planning clinic shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid recipients.

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

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients. Payment will be made for sterilization in accordance with 78.1(16).

Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other

clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. See description of enhanced services at subrule 78.25(3).

Clinics that wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Clinics shall receive reimbursement for the administration of vaccines to Medicaid recipients.

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

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

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

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The recipient has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, care coordination, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, additional care coordination services, and one postpartum

home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessments using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy.

Maternal health centers which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid recipients.

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Care coordination services shall be provided by a registered nurse; a person with at least a bachelor's degree in social work, counseling, sociology, family and community services, health or human development, health education, individual and family studies, or psychology; a person with a degree in dental hygiene; a licensed practical nurse; or a paraprofessional working under the direct supervision of a health professional.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Care coordination services, which shall include:

(1) Presumptive eligibility.

(2) Referral to WIC.

(3) Referral for dental services.

(4) Referral to physician or midlevel practitioners.

(5) Risk assessment.

(6) Arrangements for delivery, as appropriate.

(7) Arrangements for prenatal classes.

(8) Departmental multiprogram application.

(9) Hepatitis screen.

(10) Referral for eligible services.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the board of dental examiners at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942,

Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Care coordination, the coordination of comprehensive prenatal services, which shall include:

(1) Developing an individual plan of care based on the client's needs, including pregnancy and personal and interpersonal issues. This package includes counseling (such as coaching, supporting, educating, listening, encouraging, and feedback), referral, and assistance for other specified services such as mental health.

(2) Ensuring that the client receives all components as appropriate (medical, education, nutrition, psychosocial, and postpartum home visit).

(3) Risk tracking.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

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

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

Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on an eligible recipient, that can safely be performed in an outpatient setting as determined by the department upon advice from the department's utilization review and quality assurance firm.

Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on an eligible recipient, that can safely be performed in an outpatient setting for Medicaid recipients whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services covered by the Medicare program as ambulatory surgical center services in connection with Medicare-covered surgical procedures.

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

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

78.26(3) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

441—78.27(249A) Home- and community-based habilitation services.

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member's case manager has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible

for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 24.4(2) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member shall receive at least one billable unit of service other than case management per calendar quarter.

(3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS.

a. Assignment of payment slot. The number of persons who may be approved for home- and community-based habilitation services is subject to a yearly total to be served. The total is set by the department based on available funds and is contained in the Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services. The limit is maintained through the awarding of payment slots to members applying for services.

(1) The case manager shall contact the Iowa Medicaid enterprise through ISIS to determine if a payment slot is available for each member applying for home- and community-based habilitation services.

(2) When a payment slot is assigned, the case manager shall give written notice to the member.

(3) The department shall hold the assigned payment slot for the member as long as reasonable efforts are being made to arrange services and the member has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next applicant on the waiting list, if applicable. The member must reapply for a new slot.

b. Waiting list for payment slots. When the number of applications exceeds the number of members specified in the state plan and there are no available payment slots to be assigned, the member's application for habilitation services shall be denied. The department shall issue a notice of decision stating that the member's name will be maintained on a waiting list.

(1) The Iowa Medicaid enterprise shall enter the member on a waiting list based on the date and time when the member's request for habilitation services was entered into ISIS. In the event that more than one application is received at the same time, members shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) When a payment slot becomes available, the Iowa Medicaid enterprise shall notify the member's case manager, based on the member's order on the waiting list. The case manager shall give written notice to the member within five working days.

(3) The department shall hold the payment slot for 20 calendar days to allow the case manager to reapply for habilitation services by entering a program request through ISIS. If a request for habilitation services has not been entered within 20 calendar days, the slot shall revert for use by the next member on the waiting list, if applicable. The member assigned the slot must reapply for a new slot.

(4) The case manager shall notify the Iowa Medicaid enterprise within five working days of the withdrawal of an application.

c. Notice of decision. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A service plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed home- and community-based habilitation services, as well as medical, social, educational, and other services, regardless of the funding source for the services.

a. Scope. Case management services shall be provided as set forth in rule 441—90.5(249A). The case manager shall be responsible for the following activities:

(1) Explaining the member's right to freedom of choice.

(2) Ensuring that all unmet needs of the member are identified in the service plan.

(3) Retaining the comprehensive service plan, as specified in rule 441—79.3(249A).

(4) Explaining to the member what abuse is, and how to report abuse.

(5) Explaining to the member how to make a complaint about the member's services or providers.

(6) Monitoring the service plan, with review occurring regularly.

(7) Meeting with the member face to face at least quarterly.

(8) Assessing and revising the service plan at least annually to determine achievement, continued need, or changes in goals or intervention methods. The review shall include the member using the service and shall involve the interdisciplinary team.

(9) Notifying the member of any changes in the service plan by sending the member a notice of decision. When the change is an adverse action such as a reduction in services, the notice shall be sent ten days before the change and shall include appeal rights.

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities of daily living;

(3) Community inclusion;

(4) Transportation;

(5) Adult educational supports;

(6) Social and leisure skill development;

(7) Personal care; and

(8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;

(2) Physical and emotional health and development;

(3) Language and communication development;

(4) Cognitive functioning;

(5) Socialization and community integration;

(6) Functional skill development;

(7) Behavior management;

(8) Responsibility and self-direction;

(9) Daily living activities;

(10) Self-advocacy skills; or

(11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.

7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) A payment slot is not available to the member pursuant to paragraph 78.27(3)*"a."*

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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

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

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement section 249A.20A:

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

b. Automated medication dispenser. (Cross-reference 78.10(2)*"b"*) Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a recipient who either has a metabolic or digestive disorder that prevents the recipient from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the recipient's general condition. (Cross-reference 78.10(3)*"c"*(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

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

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

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the recipient is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the recipient.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3)*"c"*(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

(4) The patient has had a successful trial with an enclosed bed.

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2)*"c"*)

i. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

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

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)*"b"*)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)*"c"*)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)*"d"*)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4)*"e"*)

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

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

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.4(5)*"c"*)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the recipient has fewer than eight posterior teeth in occlusion or the recipient has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings

eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7)*"c"*)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for recipients whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the recipient is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"d"*)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for recipients whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if the recipient has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the recipient is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"e"*)

(4) Dental implants and related services will be authorized when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

d. Orthodontic services will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

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

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;
5. Openbite; and
6. Crossbite.

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

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8)*"a"*)

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3)*"d"*)

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for recipients eight years of age and older. Payment shall be made when the recipient's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the recipient is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the recipient is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) Rescinded IAB 6/4/08, effective 5/15/08.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the recipient's physician to a recipient in the recipient's place of residence or outside the recipient's residence, when normal life activities take the recipient outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the recipient.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other members of the recipient's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the recipient's physician to a recipient in the recipient's place of residence or outside the recipient's residence, when normal life activities take the recipient outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the recipient's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the recipient, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the recipient requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the recipient's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the recipient whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the recipient is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

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

441—78.29(249A) Nurse-midwives. Rescinded IAB 10/15/03, effective 12/1/03.

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services. Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

Birth centers which wish to administer vaccines which are available through the vaccines for children program to Medicaid eligibles shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid eligibles. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid recipients.

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

441—78.31(249A) Hospital outpatient services.

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

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

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

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

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

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

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

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

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

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Hospital outpatient programs that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph *"a,"* subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and

see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

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

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS MR waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

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

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

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

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

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

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

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

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

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

d. Meal preparation planning and preparing balanced meals.

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

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

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

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

(3) Helping a client with toileting.

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

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

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

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

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

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

c. Skilled nursing care is not covered.

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

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

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

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

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

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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

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

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

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

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

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

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

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

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

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

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

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy care.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

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

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

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

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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

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

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

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

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

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

c. Limitations.

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

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

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

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

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

d. A unit of service is one hour.

78.34(9) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response system.* A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency when the consumer is alone.

a. The required components of the system are:

(1) An in-home medical communications transmitter and receiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants at all times.

(4) Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year shall be the initial installation and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and what constitutes the minimum one-third daily dietary allowance.

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

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS ill and handicapped waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service selected under subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS ill and handicapped waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the following services:

(1) Assist the consumer with developing the consumer's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the consumer for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the consumer.

(5) Assist the consumer with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the consumer with obtaining a signed consent from a potential employee to conduct background checks if requested by the consumer.

(7) Assist the consumer with negotiating with entities providing services and supports if requested by the consumer.

(8) Assist the consumer with contracts and payment methods for services and supports if requested by the consumer.

(9) Assist the consumer with developing an emergency backup plan. The emergency backup plan shall also address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the consumer. Contact documentation shall include information on the extent to which the consumer's individual budget has addressed the consumer's needs and the satisfaction of the consumer.

k. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the consumer, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees, if requested.

(6) Verify for the consumer an employee's citizenship or alien status.

(7) Assist the consumer with fiscal and payroll-related responsibilities. Key employer-related tasks include:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Purchase from the individual budget workers' compensation or other forms of insurance, as applicable or if requested by the consumer.

(9) Assist the consumer in completing required federal, state, and local tax and insurance forms.

(10) Establish and manage documents and files for the consumer and the consumer's employees.

(11) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each consumer for a total of five years.

(12) Provide monthly and quarterly status reports for the department, the independent support broker, and the consumer that include a summary of expenditures paid and amount of budget unused.

(13) Establish an accessible customer service system and a method of communication for the consumer and the individual support broker that includes alternative communication formats.

(14) Establish a customer services complaint reporting system.

(15) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(16) Develop a business continuity plan in the case of emergencies and natural disasters.

(17) Provide to the department an annual independent audit of the financial management service.

(18) Assist in implementing the state's quality management strategy related to the financial management service.

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

441—78.35(249A) Certified registered nurse anesthetists. Rescinded IAB 10/15/03, effective 12/1/03.

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234) or as indicated in the Iowa department of elder affairs Annual Service and Fiscal Reporting Manual.

78.37(2) *Emergency response system.* The emergency response system allows a person experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing preestablished response protocols and personal, medical, and emergency information for each client.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

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

78.37(4) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

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

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

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

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

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

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

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

c. A unit of service is one hour.

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

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

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

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

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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

78.37(8) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets

the minimum one-third standard. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

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

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on

the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

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

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

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

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

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

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

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

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

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

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy care.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

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

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

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

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.37(16) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each

consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS elderly waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial

implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

78.37(17) *Case management services.* Case management services are services that assist a consumer in gaining access to medical, social, and other appropriate services needed for the consumer to remain in the consumer's home. Case management is provided at the direction of the consumer and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall include:

(1) A comprehensive assessment of the consumer's needs, which must be made within 30 days of referral to case management.

(2) Development and implementation of a service plan to meet those needs.

(3) Coordination, authorization, and monitoring of all services.

(4) A face-to-face meeting by the case manager with the consumer at least quarterly.

(5) Monitoring of the consumer's health, safety, and welfare.

(6) Evaluation of outcomes.

(7) Periodic reassessment and revision of the service plan as needed but at least annually.

(8) Assurance that consumers have a choice of providers.

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management activity performed on behalf of the consumer during a month when the consumer is enrolled.

d. A unit of service is one month.

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

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

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

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

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

78.38(3) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

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

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

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

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

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

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

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

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

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

h. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard. A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

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

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

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

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

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy care.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

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

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

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

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS AIDS/HIV waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

78.39(2) *Risk assessments.* Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. See description of enhanced services at subrule 78.25(3).

Federally qualified health centers which wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment,

vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients.

78.39(3) *EPSDT care coordination.* Payment for EPSDT care coordination services outlined in 78.18(6)*"b"*(2)"1" to "7" is available to MediPASS eligible providers as defined in rule 441—88.41(249A) who accept responsibility for providing EPSDT care coordination services to the MediPASS recipients under the age of 21 assigned to them on a monthly basis. All MediPASS providers shall be required to complete Form 470-3183, Care Coordination Agreement, to reflect acceptance or denial of EPSDT care coordination responsibility. When the MediPASS provider does not accept the responsibility, the MediPASS patients assigned to the MediPASS provider are automatically referred to the designated department of public health EPSDT care coordination agency in the recipient's geographical area. Acknowledgment of acceptance of the EPSDT care coordination responsibility shall be for a specified period of time of no less than six months. MediPASS providers who identify MediPASS EPSDT recipients in need of transportation assistance beyond that available according to rule 441—78.13(249A) shall be referred to the designated department of public health agency assigned to the geographical area of the recipient's residence.

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

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid recipients who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the recipient lock-in program.

78.40(4) *Vaccine administration.* Advanced registered nurse practitioners who wish to administer vaccines which are available through the vaccines for children program to Medicaid recipients shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid recipients. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid recipients.

78.40(5) *Prenatal risk assessment.* Risk assessments, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed twice during a Medicaid recipient's pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

441—78.41(249A) HCBS MR waiver services. Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through the Medicaid state plan.

All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) "Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) "Community skills training services" means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget; plan and prepare nutritional meals; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) "Personal and environmental support services" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

(6) "Treatment services" means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the consumer and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to consumers living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)*"e."*

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

[1](3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age appropriateness and individual attention span.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

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

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

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

h. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

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

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

78.41(3) *Personal emergency response system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. The necessary components of the system are:

(1) An in-home medical communications transceiver.

(2) A remote, portable activator.

(3) A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the consumer which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS MR supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the consumer's individual comprehensive plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development

services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.41(8).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

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

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

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

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

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy care.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

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

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

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

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

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

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

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

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

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

c. Limitations.

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

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

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

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

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

d. A unit of service is one hour.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS MR waiver supported community living service.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS mental retardation waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS mental retardation waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

[1] Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

441—78.42(249A) Rehabilitative treatment services. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) *Case management services.* Individual case management services means activities provided, using an interdisciplinary process, to persons with a brain injury to ensure that the consumer has received a comprehensive evaluation and diagnosis, to give assistance to the consumer in obtaining appropriate services and living arrangements, to coordinate the delivery of services, and to provide monitoring to ensure the continued appropriate provision of services and the appropriateness of the selected living arrangement.

The service is to be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks which are a typical part of life, and fully participate as members of the community. It is essential that the case manager develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers. Those who are at the ICF/MR level of care where the county has voluntarily chosen to participate in the HCBS

brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

Case management services shall consist of the following components:

a. Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.

b. Assurance that a service plan is developed which addresses the consumer's total needs for services and living arrangements.

c. Assistance to the consumer in obtaining the services and living arrangements identified in the service plan.

d. Coordination and facilitation of decision making among providers to ensure consistency in the implementation of the service plan.

e. Monitoring of the services and living arrangements to ensure their continued appropriateness for the consumer.

f. Crisis assistance to facilitate referral to the appropriate providers to resolve the crisis. The intent and purpose of the individual case services are to facilitate the consumer's access to the service system and to enable consumers and their families to make decisions on their own behalf by providing:

(1) Information necessary for decision making.

(2) Assistance with decision making and participation in the decision-making process affecting the consumer.

(3) Assistance in problem solving.

(4) Assistance in exercising the consumer's rights.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the individual comprehensive plan (ICP) or department case plan. Intermittent service shall be provided as defined in rule 441—83.81(249A).

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) Community skills training services are those activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a person to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to

a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the consumer and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to consumers living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

[1] *c.* Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)*"e."*

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

[1] (3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age appropriateness and individual attention span.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

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

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

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

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

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

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.43(13).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234).

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

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

(1) Dressing.

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

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

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

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

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

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

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of performing the essential job functions are not included in consumer-directed attendant care services.

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

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

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

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided

by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

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

(2) Intravenous therapy administered by a registered nurse.

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

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

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

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

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

(8) Colostomy.

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

(10) Postsurgical nursing care.

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

(12) Preparing and monitoring response to therapeutic diets.

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

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

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

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

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

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

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

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

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

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

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

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

c. Limitations.

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

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

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

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

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

d. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS brain injury waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

[1] Effective date of December 15, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan. Consumers shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the consumer.

a. Nonskilled service activities covered are:
(1) Help with dressing.
(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

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

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

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

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

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

(12) Assisting and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

b. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

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

(2) Assistance with intravenous therapy which is administered by a registered nurse.

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

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

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

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

(7) Rehabilitation services including bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

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

(12) Preparing and monitoring response to therapeutic diets.

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

c. A unit of service is 1 hour for up to 7 hours per day or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

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

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement.

A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

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

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

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

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, roof repair, or adding square footage to the residence, are excluded except as specifically included below. Repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the consumer's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer's service plan.

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a consumer in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.

3. Specialized medical equipment.

4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph (1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the consumer's service plan when calculating the value of that service to be included in the individual budget.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS physical disability waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services with the exception of the independent support broker and the financial management service. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The consumer may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, and medical transportation.

78.49(2) *Coordination services.* Payment shall also be approved for infant and toddler coordination services, subject to the following requirements:

a. Payable coordination services must consist of activities to assist and enable a child and family to receive infant and toddler program services and must serve as the point of contact in assisting parents to obtain the services and assistance needed. This must include, but is not limited to:

(1) Explaining the infants and toddlers with disabilities program, including parental rights and procedural safeguards.

(2) Identifying the family's concerns related to the child's needs.

(3) Coordinating the evaluations and assessments needed by the child.

(4) Facilitating and participating in the development, review and evaluation of individualized family service plans (IFSP) pursuant to rule 281—41.5(256B,34CFR300). This must include identifying the people to participate in the development of the service plan and face-to-face or telephone contacts with others for the purpose of developing, reviewing, and revising the IFSP.

(5) Assisting parents in gaining access to the infant and toddler program services and other services identified in the IFSP. This must include face-to-face or telephone contacts with the child and family for the purpose of assessing or reassessing needs.

(6) Assisting families in identifying available service providers and funding resources. This must include documentation of unmet needs and gaps in services.

(7) Coordinating and monitoring the delivery of services, informing families of the availability of advocacy services, coordinating with medical and health providers, and periodic observation of services to ensure that quality services are being provided and are effectively meeting the needs of the child.

(8) Facilitating the timely delivery of services.

(9) Continuously seeking the appropriate services for the duration of the child's eligibility.

(10) Arranging or authorizing payment for medical transportation.

(11) Keeping records, including preparing reports, updating service plans, making notes about IFSP activities in the recipient's record, and preparing and responding to correspondence with the child, family, and others.

b. A face-to-face contact between the service coordinator and the child and family is required:

(1) Within the first 30 days of service;

(2) Every three months thereafter.

c. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid-eligible individuals under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. However, the administration of vaccines is a covered service.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

78.50(2) *Coordination services.* Payment shall also be approved for local education agency services coordination, subject to the following requirements:

a. Service coordination must consist of activities to assist and enable a child to receive local education agency services and must serve as the point of contact in assisting parents to obtain the services and assistance needed. This must include, but is not limited to:

(1) Coordinating the evaluations and assessments needed by the child.

(2) Facilitating and participating in the development and review of the initial and annual individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

(3) Conducting triennial reviews.

(4) Providing ongoing service coordination.

(5) Facilitating the timely delivery of needed services.

(6) Keeping records, including preparing reports, updating service plans, making notes about IEP/IHP activities in the child's record, and maintaining face-to-face contact as required in 78.50(2)*"b."*

b. A minimum of one face-to-face contact per quarter between the service coordinator and the child and family is required for payment of local education agency coordination services.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include items installed or used within the consumer's home that address specific, documented health, mental health, or safety concerns.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the consumer's case file a signed statement from a mental health professional on the consumer's interdisciplinary team that the service has a direct relationship to the consumer's diagnosis of serious emotional disturbance.

78.52(3) *Family and community support services.* Family and community support services shall support the consumer and the consumer's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the consumer's interdisciplinary team pursuant to 441—83.127(249A).

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per consumer per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the consumer to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The "usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

a. Respite care shall not be provided to consumers during the hours in which the usual caregiver is employed, except when the consumer is attending a camp.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. *S* taff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one consumer. The consumer does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one consumer. The consumer has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more consumers receiving respite. These consumers do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

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

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

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[Filed 3/11/70; amended 3/20/74]
[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]
[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]
[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]
[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]
[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]
[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]
[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]
[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]
[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]
[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]
[Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
[Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
[Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]

[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
[Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
[Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
[Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
[Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
[Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
[Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
[Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 6/1/79]
[Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 8/29/79]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
[Filed emergency 9/6/79 after Notice 7/11/79—published 10/3/79, effective 10/1/79]
[Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
[Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
[Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
[Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
[Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
[Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
[Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
[Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
[Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
[Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
[Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
[Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
[Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
[Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
[Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
[Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
[Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83]◊
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]◊
[Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]◊
[Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]

[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
[Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
[Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
[Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
[Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
[Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
[Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
[Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
[Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed 5/29/87, Notices 4/8/87, 4/22/87—published 6/17/87, effective 8/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
[Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed 8/28/87, Notices 6/17/87, 7/15/87—published 9/23/87, effective 11/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88][1]
[Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
[Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
[Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
[Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
[Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90][1]
[Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
[Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]

[Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]
[Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]
[Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91][2]
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92][3]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
[Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
[Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92]◊
[Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
[Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]
[Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]
[Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]
[Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]
[Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]
[Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
[Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
[Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed emergency 7/14/93—published 8/4/93, effective 8/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 8/4/93—published 10/13/93, effective 12/1/93]
[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
[Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
[Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
[Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]
[Filed 9/15/94, Notices 7/6/94, 8/3/94—published 10/12/94, effective 12/1/94]

[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/5/95]
[Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]
[Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]
[Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]
[Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
[Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]◊
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
[Filed 1/15/97, Notice 12/4/96—published 2/12/97, effective 4/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 7/9/97, Notice 5/21/97—published 7/30/97, effective 10/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 1/14/98, Notice 11/19/97—published 2/11/98, effective 4/1/98]
[Filed 4/8/98, Notices 2/11/98, 2/25/98—published 5/6/98, effective 7/1/98]
[Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
[Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 3/1/99]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 6/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 10/13/99, Notice 6/30/99—published 11/3/99, effective 1/1/00]
[Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]
[Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed 10/11/00, Notice 4/19/00—published 11/1/00, effective 1/1/01]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 7/4/01]
[Filed 5/9/01, Notices 1/24/01, 3/7/01—published 5/30/01, effective 8/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]◊
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]

[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
[Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]
[Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]◊
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]◊
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02][4]
[Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]
[Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
[Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
[Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
[Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
[Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
[Filed emergency 8/15/02—published 9/4/02, effective 9/1/02]
[Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/15/02][4]
[Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
[Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]
[Filed emergency 1/9/03—published 2/5/03, effective 2/1/03]◊
[Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]
[Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]◊
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◊
[Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
[Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]◊
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed emergency 10/21/05—published 11/9/05, effective 11/1/05]
[Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]◊
[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
[Filed 5/12/06, Notice 3/15/06—published 6/7/06, effective 8/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]

[Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed without Notice 7/20/07—published 8/15/07, effective 10/1/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
[Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
[Filed emergency 6/11/08after Notice 3/12/08—published 7/2/08, effective 7/1/08]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
[Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]

◊ Two or more ARCs

1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

3 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.

4 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**.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Payments to health care providers that are owned or operated by Iowa state or non-state government entities shall not exceed the provider's cost of providing services to Medicaid members. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Monthly fee for service with cost settlement. Providers of MR/CMI/DD case management services are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in an MR/CMI/DD case management program for any portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

Providers are reimbursed throughout each fiscal year on the basis of a projected monthly rate for each participating provider, based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles) with annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on financial and statistical reports. 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.

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 which pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation, subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/08 plus 1%. Air ambulance: Fee schedule in effect 6/30/08 plus 1%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/08 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Chiropractors	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/08 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Federally qualified health centers	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $22.12 per half day, $44.03 per full day, or $66.03 per extended day if no Veterans Administration contract. For mental retardation waiver: County contract rate or, in the absence of a contract rate, $29.47 per half day, $58.83 per full day, or $75.00 per extended day.

Provider category	Basis of reimbursement	Upper limit
2. Emergency response system	Fee schedule	Initial one-time fee $49.53. Ongoing monthly fee $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.81 per hour.
5. Nursing care	For elderly and mental retardation waivers: Fee schedule as determined by Medicare.	For elderly waiver: $82.92 per visit. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%. converted to an hourly rate, not to exceed $296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$13.12 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$13.12 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$13.12 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$13.12 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.71 per half hour.
8. Home-delivered meals	Fee schedule	$7.71 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1010 lifetime maximum. For mental retardation waiver: $5050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.

Provider category	Basis of reimbursement	Upper limit
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.25 per unit.
13. Assistive devices	Fee schedule	$110.05 per unit.
14. Senior companion	Fee schedule	$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$20.20 per hour not to exceed the daily rate of $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,117 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $36.71 per day.
Individual	Fee agreed upon by consumer and provider	$13.47 per hour not to exceed the daily rate of $78.56 per day.
16. Counseling		
Individual:	Fee schedule	$10.79 per unit.
Group:	Fee schedule	$43.14 per hour.
17. Case management	Fee schedule	For brain injury waiver: $598.68 per month. For elderly waiver: $70 per month.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR per diem.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.81 per hour for personal care. Maximum of $6.19 per hour for services in an enclave setting.

Provider category	Basis of reimbursement	Upper limit
		Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6060 per year.
21. Behavioral programming	Fee schedule	$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	$43.14 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $37.44 per day. For the mental retardation waiver: County contract rate or, in absence of a contract rate, $48.22 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Child development home or center	Fee schedule	$13.12 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour.
29. In-home family therapy	Fee schedule	$93.63 per hour.
30. Financial management services	Fee schedule	$65.65 per enrolled consumer per month.
31. Independent support broker	Rate negotiated by consumer	$15.15 per hour.
32. Self-directed personal care	Rate negotiated by consumer	Determined by consumer's individual budget.
33. Self-directed community supports and employment	Rate negotiated by consumer	Determined by consumer's individual budget.
34. Individual-directed goods and services	Rate negotiated by consumer	Determined by consumer's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Home- and community-based habilitation services:		
1. Case management	Fee schedule based on MR/CMI/DD case management rates as set under 79.1(1)*"d."*	$598.68 per month.
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, $33.16 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 6/30/08 plus 1%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/08 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect on 7/01/08.

Provider category	Basis of reimbursement	Upper limit
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/08 plus 1%.
MR/CMI/DD case management providers	Monthly fee for service with cost settlement. See 79.1(1)*"d"*	Retrospective cost-settled rate.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"* (1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the	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
	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.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Physical therapists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/08 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Podiatrists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Prescribed drugs	See 79.1(8)	$4.57 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)

Provider category	Basis of reimbursement	Upper limit
Psychiatric medical institutions for children 1. Inpatient	Prospective reimbursement	Rate based on actual costs on 6/30/07, not to exceed a maximum of $167.19 per day.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule; refer to 79.1(21).
[Provider categories of "rehabilitation services for adults with a chronic mental illness" and "rehabilitative treatment services" rescinded IAB 8/1/07, effective 9/5/07; removed from IAC 10/10/07]		
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost.
Rural health clinics	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/08 plus 1%.
State-operated institutions	Retrospective cost-related	

79.1(3) *Ambulatory surgical centers.* Payment is made for facility services on a fee schedule determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report," for rates effective October 1, 2005, shall mean the hospital's cost report with fiscal year end on or after January 1, 2004, and before January 1, 2005, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and

residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. Using all applicable claims for the period January 1, 2003, through December 31, 2004, and paid through March 31, 2005, the recalibration for rates effective October 1, 2005, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 2003, to December 31, 2004, and paid through March 31, 2005. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's 2004 fiscal year and paid through March 31, 2005, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using claims and associated DRG weights only for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system,

the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific

cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph *"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

t. Limitations and application of limitations on payment. Diagnosis related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(2) Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs. The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report. The department shall determine the aggregate payments made

to the hospital under the diagnosis-related group methodology and compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount. If the payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

(3) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. Rescinded IAB 5/30/01, effective 8/1/01.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $8,642,112.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under

the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(4) Qualifying for indirect medical education. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

(5) Allocation to fund for indirect medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(6), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $15,174,101.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for indirect medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10).

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share

percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

Information contained in the hospital's available 2004 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments for July 1, 2008, through June 30, 2009, is $7,253,641.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid July 1, 2005, through June 30, 2006, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments pursuant to paragraph 79.1(5)*"ab"* cannot exceed the amount of the federal cap under Public Law 102-234. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related

Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.
2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.
3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/31/01, effective 1/1/02.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Enhanced disproportionate-share payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced disproportionate-share payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying criteria for enhanced disproportionate-share payments. A hospital qualifies for enhanced disproportionate-share payments if it qualifies for payments for disproportionate share from the graduate medical education and disproportionate-share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.
2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.
3. Is an Iowa state-owned hospital for persons with mental illness.

(2) Amount of payment. The total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate share shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate-share payments shall not exceed the hospital-specific disproportionate-share caps under Public Law 103-666.

The amount available for enhanced disproportionate-share payments shall be the federal allotment less disproportionate-share payments from the graduate medical education and disproportionate share fund. In the event that the disproportionate-share allotment for enhanced payments is insufficient to pay 100 percent of the cost that is eligible for disproportionate-share payments, the allotment shall be allocated among qualifying hospitals using their eligible cost as an allocation basis.

(3) Final disproportionate-share adjustment. The department's total year-end disproportionate-share obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

ac. Enhanced graduate medical education payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa

hospitals qualifying for enhanced graduate medical education payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying for enhanced graduate medical education payments. A hospital shall qualify for enhanced graduate medical education payments if it qualifies to receive both direct and indirect medical education payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education; or

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of graduate medical education payments from the graduate medical education and disproportionate share fund and enhanced graduate medical education shall not exceed each hospital's actual medical assistance program graduate medical education costs. The amount paid to each qualifying hospital for enhanced graduate medical education payments shall be the hospital's actual medical assistance program graduate medical education costs less the graduate medical education payments from the graduate medical education and disproportionate share fund.

(3) Final graduate medical education adjustment. The department's total year-end graduate medical education obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.331-332 as amended to April 18, 2002. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

a. Effective June 25, 2005, 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 as the average wholesale price as published by Medi-Span less 12 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 447.332, 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 drug and all equivalent products (the average price pharmacies pay to obtain drugs as evidenced by purchase records) adjusted by a multiplier of 1.4, 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. Effective June 25, 2005, reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 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 after June 30, 2008, the professional dispensing fee is $4.57 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.

[1](4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base-year cost report," for rates effective July 1, 2008, shall mean the hospital's cost report with fiscal year end on or after January 1, 2006, and before January 1, 2007. Cost reports shall be reviewed using Medicare's cost-reporting and cost reimbursement principles for those cost-reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. For dates of services beginning on or after July 1, 2008, the department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a bill type other than outpatient hospital. ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or	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.

	• For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Blood and blood products Brachytherapy sources Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.

L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q	Packaged services subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria. If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.

		If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*
3. The total calculated Medicaid cost for ambulance services.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost

audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Hospital billing. Rescinded IAB 07/02/08, effective 07/01/08.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs.

(1) The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report.

(2) The department shall determine the aggregate payments made to the hospital under the APC methodology and shall compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, aggregate payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount.

(3) If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(16)*"v"*(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services for July 1, 2008, through June 30, 2009, is $2,922,460.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/29/03, effective 1/1/04.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each

of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for rehabilitation services for adults with chronic mental illness.* Rescinded IAB 8/1/07, effective 9/5/07.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is one month.

(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.

[1] October 1, 2002, effective date 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 delayed the effective date until adjournment of the 2003 Session of the General Assembly.

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.
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. Individual treatment plan.
6. Reassessment of member needs.

(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.

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.

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 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. Elections will be held the first meeting after the beginning of the calendar year.

b. The term of office shall be two years. Officers shall serve no more than two terms for each office.

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 nominating committee of not less than three members and shall appoint other committees approved by the council.

79.7(2) *Alternates.* Each organization represented may select one alternate as representative when the primary appointee is unable to be present. Alternates may attend any and all meetings of the council, but only one representative of each organization shall be allowed to vote.

79.7(3) *Expenses.* The travel expenses of the public representatives and other expenses, 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.

79.7(4) *Meetings.* The council shall meet at least four times each year. At least two of these meetings shall be with the department of human services. Additional 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 such meetings. 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 alternate and to the executive office of each organization or body represented.

d. Notice shall be made to the representing organization when the member, or alternate, 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.* The medical assistance advisory council shall:

a. Make recommendations on the reimbursement for medical services rendered by providers of services.

b. Assist in identifying unmet medical needs and maintenance needs which affect health.

c. Make recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

d. Reserved.

e. Reserved.

f. Recommend ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

g. Advise on such administrative and fiscal matters as the commissioner of the department of human services may request.

h. Advise professional groups and act as liaison between them and the department.

i. Report at least annually to the appointing authority.

j. Perform other functions as may be provided by state or federal law or regulation.

k. Communicate information considered by the council to the member organizations and bodies.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the member organizations and bodies. The department will consider all advice and counsel of the council.

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, regulations, 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 and alternates on the council.

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.

[Filed March 11, 1970]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 3/25/77, Notice 12/1/76—published 4/20/77, effective 5/25/77]
[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]
[Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 10/10/78, Notice 7/26/78—published 11/1/78, effective 12/6/78]
[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]
[Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]
[Filed 12/5/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency 4/23/81—published 5/13/81, effective 4/23/81]
[Filed 8/24/81, Notice 3/4/81—published 9/16/81, effective 11/1/81]
[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
[Filed 7/30/82, Notice 6/9/82—published 8/18/82, effective 10/1/82]
[Filed emergency 8/20/82 after Notice of 6/23/82—published 9/15/82, effective 10/1/82]
[Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]
[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]

[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
[Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
[Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
[Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
[Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
[Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]*
[Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
[Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]◊
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
[Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
[Filed 12/22/88, Notices 11/16/88—published 1/11/89, effective 3/1/89]◊
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90][2]
[Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
[Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
[Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]
[Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]

[Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 8/16/90, Notices 7/11/90—published 9/5/90, effective 11/1/90][4]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91]***
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92][3]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
[Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]
[Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
[Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]
[Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
[Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
[Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
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[Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
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[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
[Filed 3/10/94, Notices 1/19/94, 2/2/94—published 3/30/94, effective 6/1/94]◊
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]
[Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]

[Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]◊
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
[Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]
[Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]
[Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
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[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
[Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
[Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]◊
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
[Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02][4]
[Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]*
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
[Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]

[Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
[Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]*
[Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
[Filed 8/15/02, Notice 6/12/02—published 9/4/02, effective 11/1/02]
[Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 11/1/02]
[Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
[Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
[Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
[Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]◊
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]◊
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]◊
[Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]◊
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]◊
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
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[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]◊
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
[Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]◊
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
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[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed emergency 8/9/07 after Notice 7/4/07—published 8/29/07, effective 8/10/07]
[Filed 8/9/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 10/10/07—published 11/7/07, effective 10/10/07]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
[Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

◊ Two or more ARCs

[1] Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

[2] Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

[3] Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

[4] Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

[5] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

441—83.1(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Blind individual" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of ill and handicapped waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled person" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Intermittent homemaker service" means homemaker service provided from one to three hours a day for not more than four days per week.

"Intermittent respite service" means respite service provided from one to three times a week.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for the mentally retarded which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Substantial gainful activity" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.2(249A) Eligibility. To be eligible for ill and handicapped waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving ill and handicapped waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for the mentally retarded. The IME medical services unit shall be responsible for approval of the certification of the level of care.

Ill and handicapped waiver services will not be provided when the individual is an inpatient in a medical institution.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at paragraphs 441—75.5(2)*"b"* and 441—75.5(4)*"c"* shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The consumer shall have a service plan approved by the department which is developed by the service worker identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker shall establish the interdisciplinary team for the consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 is completed annually, or more frequently

upon request or when there are changes in the consumer's condition. The service worker shall have a face-to-face visit with the consumer at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the consumer's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the ill and handicapped waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/MR
$2,631	$904	$3,203

(1) For consumers eligible for SSI who remain eligible for ill and handicapped waiver services until the age of 25 because they are receiving ill and handicapped waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the consumer would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than $500 is paid for home and vehicle modification services, the service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

441—83.3(249A) Application.

83.3(1) *Application for HCBS ill and handicapped waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS ill and handicapped waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of consumers to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of consumers specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall contact the bureau of long-term care for all applicants for the waiver to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the bureau by the end of the fifth working day after receipt of either Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, with the choice of HCBS waiver indicated by signature of the consumer or a written request signed and dated by the consumer.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the bureau of long-term care shall enter persons on a waiting list according to the following:

(1) Consumers not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is date-stamped in the county department office or upon the county department office's receipt of disability determination, whichever is later.

(2) Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)*"a"*(2) is date-stamped in the county department office.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS ill and handicapped waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

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

(4) The application is pending because a level of care determination has not been made although the completed assessment, Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-0659, or the service plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form 470-0659, or service plan, the application shall be denied. The consumer shall have the right to appeal.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. A consumer must be given the choice between HCBS ill and handicapped waiver services and institutional care. The income maintenance or service worker shall have the consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care complete and sign Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, indicating the consumer's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A consumer may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs *"a"* and *"c"* of this subrule do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subrule 83.2(1)*"c"*(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care. Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

441—83.7(249A) Service plan. A service plan shall be prepared for ill and handicapped waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The client receives care in a hospital, nursing facility, or intermediate care facility for the mentally retarded for 30 days in any one stay for purposes other than respite care.

d. The client receives ill and handicapped waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

d. Certified as being in need of the intermediate or skilled level of care. The IME medical services unit shall be responsible for approval of the certification of the level of care.

Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. Case management. As a condition of eligibility, all consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). The case manager shall be responsible for doing the following:

(1) Making a comprehensive assessment of the consumer's needs within 30 days of referral to case management.

(2) Initiating development and review of the service plan as required by this subrule.

(3) Ensuring that the consumer exhausts all services available under the state Medicaid plan before accessing the waiver.

(4) Ensuring that all unmet needs of the consumer are identified in the service plan.

(5) Explaining the following to the consumer:

1. What abuse is and how to report abuse.
2. How to file a complaint about the consumer's services or providers.
3. The consumer's right to freedom of choice.

(6) Verifying that providers of consumer-directed attendant care are adequately skilled to meet the needs of the consumer.

b. Interdisciplinary team. The case manager shall establish an interdisciplinary team for the consumer.

(1) Composition. The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer's legal representative, family, service providers, and others directly involved in the consumer's care.

(2) Role. The team shall identify:

1. The consumer's need for services based on the consumer's needs and desires.
2. Available and appropriate services to meet the consumer's needs.
3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. Service plan. An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the consumer. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

Skilled level of care	Nursing level of care
$2,631	$1,117

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
2. The emergency backup support and crisis response system identified by the interdisciplinary team.
3. Emergency, backup staff designated by providers for applicable services.

83.22(3) *Providers—standards.* Rescinded IAB 10/11/06, effective 10/1/06.

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) *Approval of application.*

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The consumer, guardian, or attorney in fact under a durable power of attorney for health care shall sign the service plan indicating the consumer's choice of caregiver.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility cannot precede the date the case manager signs the case plan.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.22(2)*"b,"* or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to **83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital. The IME medical services unit shall be responsible for approval of the certification of the level of care. AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The county social worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1,751.

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made or pended although the completed assessment, Form 470-0659, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. A consumer must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The income maintenance or service worker shall have the consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care complete and sign Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, indicating the consumer's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations and the service plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, an appeal may be filed with the department.

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS MR WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with mental retardation aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with mental retardation aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the consumer and caregiver by a qualified mental retardation professional (QMRP) to facilitate home management of the consumer and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Mental retardation" means a diagnosis of mental retardation under this division which shall be made only when the onset of the person's condition was prior to the age of 18 years and shall be based on an assessment

of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Person with a related condition" means an individual who has a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a mentally retarded person and requires treatment or services similar to those required for a mentally retarded person.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified mental retardation professional" means a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. A professional dietitian who is eligible for registration by the American Dietetics Association.

10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.61(249A) Eligibility. To be eligible for HCBS MR waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of mental retardation or, for residential-based supported community living services only, be a person with a related condition as defined in rule 441—83.60(249A). Those eligible based on a primary diagnosis of mental retardation must have the diagnosis initially established and recertified as follows:

Age	Initial application to HCBS MR waiver program	Recertification for persons with an IQ range of 54 or below, moderate range of MR or below	Recertification for persons with an IQ range of 55 or above, diagnosis of mild or unspecified range of MR
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or mental disability equivalent to mental retardation	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every six years and when a significant change occurs	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or mental disability equivalent to mental retardation every three years and when a significant change occurs
18 through 21 years	• Psychological documentation substantiating diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation within three years prior to age 18, or • Diagnosis of mental retardation or mental disability equivalent to mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five years and whenever a significant change occurs
22 years and above	Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation, if the last testing date was (1) more than five	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five years and whenever a significant change occurs

Age	Initial application to HCBS MR waiver program	Recertification for persons with an IQ range of 54 or below, moderate range of MR or below	Recertification for persons with an IQ range of 55 or above, diagnosis of mild or unspecified range of MR
	years ago for consumers with an IQ range of 55 or above or with a diagnosis of mild mental retardation, or (2) more than ten years ago for consumers with an IQ range of 54 or below or with a diagnosis of moderate MR or below		

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/MR. The IME medical services unit shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For supported employment services:

(1) Be at least age 16.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Choose HCBS MR waiver services rather than ICF MR services.

i. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

j. Be assigned an HCBS MR payment slot pursuant to subrule 83.61(4).

k. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;
2. Case history that includes previous placements and service programs;
3. Medical history that includes major illnesses and current medications;
4. Current psychological evaluations and consultations;
5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
6. Any current court orders in effect regarding the child;
7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/MR;

2. Be at risk of ICF/MR placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

l. For day habilitation, be 16 years of age or older.

m. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Consumers currently receiving Medicaid case management or services of a department-qualified mental retardation professional (QMRP) shall have the applicable coordinating staff and other interdisciplinary team members complete the Functional Assessment Tool, Form 470-3073, and identify the consumer's needs and desires as well as the availability and appropriateness of the services.

b. Consumers not receiving services as set forth in paragraph *"a"* who are applying for the HCBS MR waiver service shall have a department service worker or a case manager paid by the county without Medicaid funds complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination; establish an initial interdisciplinary team for HCBS MR services; and, with the initial interdisciplinary team, identify the consumer's needs and desires as well as the availability and appropriateness of services.

c. Persons meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The service worker, department QMRP, or Medicaid case manager shall complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-3073 or other circumstances beyond the worker's control.

g. At initial enrollment the service worker, department QMRP, case manager paid by the county without Medicaid funds, or Medicaid case manager shall establish an HCBS MR interdisciplinary team for each consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Functional Assessment Tool, Form 470-3073.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

(4) Service plans for consumers aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care or the designee of the county board of supervisors. The service worker, department QMRP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS MR program limit.* The number of persons receiving HCBS MR waiver services in the state shall be limited to the number of payment slots provided in the HCBS MR waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit annually to be effective each July 1 based upon the county management plans submitted by the state and counties. The department shall also submit a request to CMS for changes to the program limit to be effective January 1 if requested by a county during the month of September.

a. The payment slots are on a county basis for adults with legal settlement in a county and are on a statewide basis for children and adults without a county of legal settlement. These slots shall be available on a first-come, first-served basis.

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.*

a. The county department office shall contact the bureau of long-term care for state cases and children or the central point of coordination administrator for the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS MR program.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau or the county by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid recipients, the county department office shall contact the bureau or the county by the end of the fifth working day after receipt of either Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, with the choice of HCBS waiver indicated by signature of the consumer or a written request signed and dated by the consumer.

(3) A payment slot is assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the bureau of long-term care shall enter persons on a waiting list according to the following:

(1) Consumers not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is date-stamped in the county department office or upon county department office receipt of disability determination, whichever is later.

(2) Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the request as specified in 83.61(4)*"a"*(2) is date-stamped in the county department office.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list. The county central point of coordination administrator (for adults) and the bureau of long-term care (for children and for adults with state case status) shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care for state cases and children or the central point of coordination administrator for the county of legal settlement for adults within five working days of the receipt of an application and of any action on or withdrawal of an application.

441—83.62(249A) Application.

83.62(1) *Application for HCBS MR waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS MR waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/MR care. The case manager or worker shall have the consumer or legal representative complete and sign Part A of Form 470-3073, Mental Retardation Functional Assessment Tool, indicating the consumer's choice of care.

d. HCBS MR waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS MR waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Children who were receiving rehabilitative treatment and supportive services under the group care program pursuant to 441—Chapter 185, division V, who were placed with a rehabilitative treatment and supportive service provider as a result of a delinquency or CINA adjudication will be ineligible unless a the department service area manager or the service area manager's designee determines that the child would have been eligible and the services covered aside from the adjudication. The service area manager or designee shall base an approval or denial on documentation regarding the child's individual situation. This documentation shall include, but is not limited to, the following:

(1) The reason for the adjudication.

(2) The existence of mental retardation or a related condition and the role of the child's mental retardation or related condition in the adjudication.

(3) Other possible placements suitable for the child that would meet the child's needs.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the

interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS MR waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS MR waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS MR waiver consumer.

83.67(1) *Development.* The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of the consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) *Documentation.* The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) *Approval of plan.* The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

a. Services must be authorized and entered into ISIS before the plan implementation date.

b. The department or county has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department or county and service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department or county has final authority regarding the services and service cost.

d. If a notice of decision is not received from a county within 30 days from the date of request for services, the request shall be sent to the department of human services with documentation verifying the original submission of the request to the county. The department shall send a letter to the county central point of coordination and county board of supervisors requesting a response within 10 days. If no response is received within 10 days, the department will make the decision, as stated in paragraph *"b."*

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The HCBS MR service is not identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The HCBS MR service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or consumer is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—paragraph 25.13(2)*"j."* If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department pursuant to rule 441—83.69(249A).

441—83.70(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the HCBS MR waiver service expenses to adults. The county shall enter into a payment agreement with the department for reimbursement of the nonfederal share of the cost of service provided to HCBS MR waiver adults by input through the Individualualized Services Information System (ISIS).

83.70(1) *County agreement.* The county shall enter into the agreement using the criteria in subrules 83.61(2) and 83.62(1).

83.70(2) *Continuation of services for HCBS MR consumers.* The county shall continue to provide HCBS MR services to consumers with mental retardation who are enrolled in the HCBS MR program on August 1, 1996. The county shall continue to provide HCBS MR services to children who are enrolled in the HCBS MR program after the children turn 18. The state slot for a child in the HCBS MR program will transfer to the county of legal settlement when the child turns 18.

83.70(3) *Continuation of services for children receiving residential-based supported community living services.* The county of legal settlement shall be given the option to continue to provide funding for appropriate services to a child 18 to 21 years of age who is receiving residential-based supported community living services after the child turns 18. The case manager shall notify the county of legal settlement when the child in placement turns 16. For children placed after the age of 16, the case manager shall notify the county of legal settlement at the time of placement.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Recipients of the HCBS MR waiver program may be eligible for a rent subsidy program. See 441—Chapter 53.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to **83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.
Malignant neoplasms of brain, temporal lobe.
Malignant neoplasms of brain, parietal lobe.
Malignant neoplasms of brain, occipital lobe.
Malignant neoplasms of brain, ventricles.
Malignant neoplasms of brain, cerebellum.
Malignant neoplasms of brain, brain stem.
Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.
Malignant neoplasms of brain, cerebral meninges.
Malignant neoplasms of brain, cranial nerves.
Secondary malignant neoplasm of brain.
Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
Benign neoplasm of brain and other parts of the nervous system, brain.
Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
Encephalitis, myelitis and encephalomyelitis.
Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

"Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be aged 1 month to 64 years.

d. Be a U.S. citizen and Iowa resident.

e. Rescinded IAB 7/11/01, effective 7/1/01.

f. Be determined by the IME medical services unit as in need of intermediate care facility for the mentally retarded (ICF/MR), skilled nursing, or ICF level of care.

g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

83.82(2) *Need for services.*

a. The consumer shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed prior to services provision and annually thereafter.

The case manager shall establish the interdisciplinary team for the consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for consumers aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee, or for a consumer at the ICF/MR level of care, the designee of the county of legal settlement's board of supervisors, to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no

more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services shall not exceed $2,812 per month. If more than $500 is paid for home and vehicle modification services, the service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall contact the bureau of long-term care to determine if a payment slot is available for all new applications for the HCBS BI waiver program. For new applications for people who require the ICF/MR level of care when the county of legal settlement has payment responsibility pursuant to rule 441—83.90(249A), the county department office shall inform the county of legal settlement of the application.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau and notify the county of those applicants for whom the county has payment responsibility by the end of the second working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application.

(2) For current Medicaid recipients, the county department office shall contact the bureau and notify the county of those persons for whom the county has payment responsibility by the end of the second working day after receipt of either Form 470-3349, Brain Injury Functional Assessment, with the choice of the HCBS waiver indicated by the consumer's signature, or a written request signed and dated by the consumer.

b. On the third day after the receipt of the completed Form 470-2927 or 470-2927(S), if no payment slot is available, the bureau of long-term care shall enter the consumer on a waiting list according to the following:

(1) Consumers not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS BI program services as documented by the date of the consumer's signature on Form 470-2927 or 470-2927(S). In the event that more than one application is received at one time, consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

The county shall have financial responsibility for the state share of the costs of services for these consumers as stated in rule 441—83.90(249A). The county shall include these ICF/MR level of care brain-injured consumers in their annual county management plan which is approved by the state.

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. A consumer shall be given the choice between waiver services and institutional care. The consumer or legal representative shall complete and sign Form 470-3349, Brain Injury Functional Assessment, indicating the consumer's choice of caregiver. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of a consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services.

Service plans for consumers aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care, or when a county voluntarily chooses to participate, by the county board of supervisors' designee or the bureau's designee. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The IME medical services unit shall assess the consumer annually and certify the consumer's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Brain Injury Waiver Functional Assessment, Form 470-3283, and supporting documentation as needed.

83.87(4) *Service file.* The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to *d.* Rescinded IAB 8/7/02, effective 10/1/02.

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or consumer is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or consumer may file an appeal with the department.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—paragraph 25.13(2)*"j."* If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department pursuant to rule 441—83.69(249A).

441—83.90(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the cost of brain injury waiver services to consumers at the ICF/MR level of care with legal settlement in the county who are coming onto the waiver from an ICF/MR facility or who have been receiving other services for which the county has been financially responsible or would become liable due to the person's reaching the age of majority. The county shall enter into a payment agreement with the department for reimbursement of the nonfederal share of the cost of services provided to adults who meet the criteria stated above by input through the Individualized Services Information System (ISIS). Waiver slots for these persons shall be identified in the county management plan submitted to the department pursuant to 441—Chapter 25.

The county shall enter into the agreement using the criteria in subrule 83.82(2).

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to **83.100** Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Department" means the Iowa department of human services.

"Guardian" means a guardian appointed in probate court for an adult.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS MR waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Rescinded IAB 2/7/01, effective 2/1/01.

h. Be in need of skilled nursing or intermediate care facility level of care. Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical

information. After notice of an adverse decision by the IME medical services unit, the Medicaid applicant or recipient or the applicant's or recipient's representative may request reconsideration by the IME medical services unit pursuant to subrule 83.109(2). On initial and reconsideration decisions, the IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2). Adverse decisions by the IME medical services unit on reconsiderations may be appealed to the department pursuant to 441—Chapter 7 and rule 441—83.109(249A).

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The consumer shall have a service plan which is developed by the consumer and a department service worker. This must be completed and approved prior to service provision and at least annually thereafter.

The service worker shall identify the need for service based on the needs of the consumer as well as the availability and appropriateness of services.

b. The total cost of physical disability waiver services shall not exceed $659 per month. If more than $500 is paid for home and vehicle modification services, the service worker shall encumber up to $500 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall contact the bureau of long-term care for all cases to determine if a slot is available for all new applications for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau by the end of the second working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, submitted on or after April 1, 1999.

(2) For current Medicaid recipients, the county department office shall contact the bureau by the end of the second working day after receipt of Form 470-3502, Physical Disability Waiver Assessment Tool, with the choice of HCBS waiver indicated by the signature of the consumer or a written request signed and dated by the consumer.

b. On the third day after the receipt of the completed Form 470-2927 or 470-2927(S), Health Services Application, if no slot is available, the bureau of long-term care shall enter consumers on the HCBS physical disabilities waiver waiting list according to the following:

(1) Consumers not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is submitted on or after April 1, 1999, and date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added on the basis of the date the consumer requests HCBS physical disability program services as documented by the date of the consumer's signature on Form 470-2927 or 470-2927(S). In the event that more than one application is received on the same day, consumers shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application. The discharge planner shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the IME medical services unit. After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community. The applicant, the applicant's parent, the applicant's legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the IME medical services unit. After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-3502, Physical Disability Waiver Assessment Tool, indicating the applicant's choice of caregiver.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.102(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the consumer.

e. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) *Annual assessment.* The IME medical services unit shall review the consumer's need for continued care annually and recertify the consumer's need for long-term care services, pursuant to the standards and subject to the reconsideration and appeal processes at paragraph 83.102(1)*"h"* and rule 441—83.109(249A), based on the completed Form 470-3502, Physical Disability Waiver Assessment Tool, and supporting documentation as needed. Form 470-3502 is completed by the service worker at the time of recertification.

83.107(3) *Case file.* Rescinded IAB 8/7/02, effective 10/1/02.

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) *Appeal to county.* Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) *Reconsideration request to IME medical services unit.* After notice of an adverse decision by the IME medical services unit on the level of care requirement pursuant to paragraph 83.102(1)*"h,"* the Medicaid applicant or recipient or the applicant's or recipient's representative may request reconsideration by the IME medical services unit by sending a letter requesting a review to the IME medical services unit not more than 60 days after the date of the notice of adverse decision. Adverse decisions by the IME medical services unit on reconsiderations may be appealed to the department pursuant to 441—Chapter 7.

a. If a timely request for reconsideration of an initial denial determination is made, the IME medical services unit shall complete the reconsideration determination and send written notice including appeal rights to the Medicaid applicant or recipient and the applicant's or recipient's representative within ten working days after the IME medical services unit receives the request for reconsideration and a copy of the medical record.

b. If a copy of the medical record is not submitted with the reconsideration request, the IME medical services unit will request a copy from the facility within two working days.

c. The notice to parties. Written notice of the IME medical services unit's reconsidered determination will contain the following:

(1) The basis for the reconsidered determination.

(2) A detailed rationale for the reconsidered determination.

(3) A statement explaining the Medicaid payment consequences of the reconsidered determination.

(4) A statement informing the parties of their appeal rights, including the information that must be included in the request for hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

d. If the request for reconsideration is mailed or delivered to the IME medical services unit within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this rule will be treated as an overpayment to be paid back to the department.

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to **83.120** Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

"Case manager" means the person designated to provide Medicaid targeted case management services for the consumer.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Consumer" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

"Deeming" means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

"Department" means the Iowa department of human services.

"Guardian" means a parent of a consumer or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME" means the Iowa Medicaid enterprise.

"IME medical services unit" means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children's mental health waiver services.

"Interdisciplinary team" means the consumer, the consumer's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer's needs, as designated by the consumer and the consumer's family, who meet to develop a service plan based on the individualized needs of the consumer.

"ISIS" means the department's individualized services information system.

"Local office" means a department of human services office as described in 441—subrule 1.4(2).

"Medical institution" means a nursing facility, an intermediate care facility for the mentally retarded, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a written, consumer-centered, outcome-based plan of services developed by the consumer's interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

"Skill development" means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) *Age.* The consumer must be under 18 years of age.

83.122(2) *Diagnosis.* The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as

determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The consumer must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the consumer's level of care annually based on Form 470-4211, Children's Mental Health Waiver Assessment.

83.122(4) *Financial eligibility.* The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The consumer must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the consumer's parent or legal guardian on Form 470-4211, Children's Mental Health Waiver Assessment.

83.122(6) *Need for service.* The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the consumer's needs may not exceed $1,873 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and any of the following services at the same time:

(1) Rehabilitative treatment services under 441—Chapter 185; or

(2) Family foster care under 441—Chapter 202.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4211, Children's Mental Health Waiver Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of consumers not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is submitted and date-stamped in the local office;

(2) The names of Medicaid members shall be added to the waiting list on the date Form 470-4211, Children's Mental Health Waiver Assessment, or a written request as specified in 83.123(2)*"a"*(3) is date-stamped in the local office.

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment or the service plan has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a service plan, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level-of-care determinations and the consumer's service plan are completed.

83.123(3) *Effective date of eligibility.* The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met;

b. Eligibility and level-of-care determinations have been made; and

c. The service plan has been completed.

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) *Eligibility review.* Every 12 months, the local office shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

a. Continuing eligibility factors as specified in rule 441—83.122(249A).

b. The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).

83.125(2) *Continuation of eligibility.* A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A**)**.

b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) *Payment slot.* When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in Form 470-4211, Children's Mental Health Waiver Assessment.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services shall be denied when the department determines that:

a. The consumer is not eligible for or in need of waiver services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6)*"c"* or are not met by the services provided.

83.128(2) *Termination.* A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6)*"c."*

c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services shall apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). An applicant or consumer may obtain a review of the IME medical services unit's level-of-care determination by sending a letter requesting a review to the IME Medical Services Unit, P.O. Box 36478, Des Moines, Iowa 50315. If dissatisfied with the IME medical services unit's review decision, the applicant or consumer may file an appeal with the department in accordance with 441—Chapter 7.

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 5/13/88 after Notice 3/23/88—published 6/1/88, effective 6/1/88]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
[Filed emergency 5/17/91 after Notice of 4/3/91—published 6/12/91, effective 7/1/91]
[Filed 10/10/91, Notice 9/4/91—published 10/30/91, effective 1/1/92]
[Filed emergency 1/16/92, Notice 11/27/91—published 2/5/92, effective 3/1/92]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 7/17/92, Notice 5/13/92—published 8/5/92, effective 10/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed 8/12/93, Notice 4/28/93—published 9/1/93 effective 11/1/93]
[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
[Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]
[Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]
[Filed emergency 7/15/94 after Notice 6/8/94—published 8/3/94, effective 8/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/1/95]
[Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 11/16/95, Notices 8/2/95, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 8/15/96, Notice 6/19/96—published 9/11/96, effective 11/1/96]
[Filed emergency 10/9/96 after Notice 8/14/96—published 11/6/96, effective 11/1/96]
[Filed 1/15/97, Notice 11/20/96—published 2/12/97, effective 4/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 10/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 12/10/97, Notice 11/5/97—published 12/31/97, effective 4/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 10/1/98]
[Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 4/1/99]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed emergency 9/13/99—published 10/6/99, effective 10/1/99]
[Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]

[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed emergency 1/10/01 after Notice 11/29/00—published 2/7/01, effective 2/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
[Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
[Filed emergency 6/12/03 after Notice 4/30/03—published 7/9/03, effective 6/15/03]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed emergency 9/23/04—published 10/13/04, effective 10/1/04]
[Filed 12/14/04, Notice 10/13/04—published 1/5/05, effective 2/9/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed emergency 11/8/06—published 12/6/06, effective 12/1/06]
[Filed 1/12/07, Notice 12/6/06—published 2/14/07, effective 3/21/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

CHAPTER 92
IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code Supplement section 249J.6.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1)*"b."*

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) *Persons covered.* Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph *"b."*

92.2(2) *Citizenship.* To be eligible for IowaCare benefits, a person must meet the requirements in 441—paragraph 75.11(2)*"a."* A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) *Other disqualification.* A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) *Group health insurance.* A person who has access to group health insurance is not eligible for IowaCare. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) *Payment of assessed premiums.* As a condition of eligibility for IowaCare, an applicant or member must pay premiums in accordance with 441—92.7(249A,249J). Premiums incurred and unpaid from a previous certification period must be paid in full before an applicant can establish new eligibility under this chapter.

92.2(6) *Availability of funds.* Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) shall also sign Form 470-4194, IowaCare Premium Agreement.

92.3(2) A new application is required for each 12-month certification period.

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) *Verification.* Applicants seeking eligibility under 92.2(1)*"b"* shall provide verification of medical expenses as required under 92.5(5)*"b."* IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

92.4(2) *Screening for full Medicaid.* The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) *Time limit for decision.* The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) *Household size.* The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

b. The conditions described in 441—paragraph 75.53(4)*"b"* shall be applied to determine whether a person's absence is temporary.

92.5(2) *Self-declaration of income.* Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) *Earned income.* All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1)*"b"*(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3)*"b."*

92.5(4) *Unearned income.* Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph *"b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z,"* or *"aa"*; or

b. 441—subrule 75.57(7), paragraph *"a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m,"* or *"q."*

92.5(5) *Deductions.* The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1)*"b,"* medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

92.5(6) *Disregard of changes.* A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) *Unearned nonrecurring lump-sum income.* All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) *Earned lump-sum income.* Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) *Certification period.* IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months or, for women and newborns eligible under 92.2(1)*"b"* or *"c,"* until 60 days after the birth of the child.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c,"* shall be assessed a sliding-scale monthly premium. No premium shall be assessed at the time of initial application for months of eligibility before and including the month of decision, including the retroactive month. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for a 12-month period beginning with the first month of eligibility, based on projected monthly income for the 12-month period.

a. The monthly premium amount is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. Effective April 1, 2008, premium amounts based on this percentage are as follows:

When the household's income is at or below:	Each member's premium amount is:
100% of federal poverty level	$ 0
110% of federal poverty level	$43
120% of federal poverty level	$47
130% of federal poverty level	$52
140% of federal poverty level	$56
150% of federal poverty level	$60
160% of federal poverty level	$64
170% of federal poverty level	$69
180% of federal poverty level	$73
190% of federal poverty level	$77
200% of federal poverty level	$82

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment for a one-person household. Households with income at or below 100 percent of the poverty level are not subject to a premium. Premiums for households with income over 100 percent of the poverty level are 5 percent of the applicable income level. The department will update these amounts annually on April 1 using the latest federal poverty level guidelines.

c. The cost of premiums paid for HAWK-I shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a 12-month certification period shall not be increased due to an increase in income or a change in household size.

e. The premium may be reduced prospectively during the 12-month certification period if the member declares a reduction in projected average monthly income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. Method of payment. Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013. Members may also submit premium payments to the Broadlawns Medical Center or other designated office that makes arrangements for armored delivery of the payments to the department's agent for receiving payments.

b. Due date. When the department notifies the member of the amount of the premiums, the member shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month forward. When premiums for all months have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."* If the statement is not postmarked by the premium due date, the member shall be obligated to pay the premium.

a. A partial payment submitted with a written statement indicating that full payment of the monthly premium will be a financial hardship that is postmarked or received on or before the end of the month for which the premium is due shall be considered a request for a hardship exemption. The exemption shall be granted for the balance owed for that month.

b. If the postmark is illegible, the date that the hardship declaration is initially received by the department or the department's designee shall be considered the date of the request.

c. A member shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective the last day of the next calendar month. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded.

a. The premium obligation is reduced to zero when a member's IowaCare coverage is canceled because the member:

(1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);

(2) Has access to group health insurance coverage as defined in subrule 92.2(4);

(3) Reaches age 65;

(4) Dies; or

(5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for an individual not receiving IowaCare benefits shall be refunded after two calendar months unless an application or reapplication is pending or upon the individual's request.

d. Any excess premium received for an IowaCare member shall be refunded after two calendar months of a zero premium or upon the member's request.

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) and 92.8(4), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A state mental health institute, exclusive of the units providing substance abuse treatment, services to gero-psychiatric patients, or treatment for sexually violent predators; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel pursuant to 441—subrule 78.1(13).

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78, 441—79.9(249A), and 441—Chapter 85, Division I. All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1)*"b"* or *"c"* are also eligible for the services specified in paragraph *"a"* or *"b"* from the providers specified in paragraph *"c"* or *"d."*

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center. Physician assistants are able to render covered services as auxiliary personnel pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

441—92.9(249A,249J) Claims. Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or

b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3)*"a"* or *"b"* applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—76.12(249A).

92.13(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

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

[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed emergency 7/15/05—published 8/3/05, effective 7/15/05]
[Filed 12/14/05, Notices 7/6/05, 8/3/05—published 1/4/06, effective 3/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 10/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 3/14/07—published 4/11/07, effective 4/1/07]
[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]
[Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
[Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
[Filed 10/10/07, Notice 8/1/07—published 11/7/07, effective 1/1/08]
[Filed emergency 4/9/08—published 5/7/08, effective 4/9/08]
[Filed emergency 6/11/08after Notice 3/12/08 —published 7/2/08, effective 7/1/08]
[Filed emergency 6/12/08 after Notice 4/23/08—published 7/2/08, effective 7/1/08]

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
CATEGORIES OF CONTRACTS, 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 PROVIDER ADVISORY COMMITTEE AND 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 Iowa donation of funds contract establishes the conditions under which a donor makes funds available to the department. This is generally for the purpose of matching state or federal funds for services or administrative support. The contract shall contain specifications concerning amendment, termination, transmittal of funds, accounting, and reversion of unspent funds. The donor may specify the geographic area to be served and the specific service to be provided. The Iowa Donation of Funds Contract, Form 470-0629, shall be completed prior to the department's acceptance of the funds.

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, except when providing services as described in 441—Chapter 182, for which the requirements in 441—subrules 185.10(4), 185.10(5) and 185.10(6) shall apply, as specified in rule 441—182.7(234):

(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, except for services described in 441—Chapter 182, for which the requirements of rule 441—182.7(234) shall apply.

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. Rates for community resource procurement, family team meeting facilitation, and relative home study services, as described in rule 441—182.2(234), shall be:

(1) Established in accordance with 441—subrule 185.112(14); and

(2) Subject to the provisions of 441—subrules 152.2(23) and 152.2(25).

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, 2008, the maximum reimbursement rates for services provided under a purchase of social service agency contract (shelter care and supervised apartment living) shall be increased to 1 percent over the rates in effect on June 30, 2008, or increased to the provider's actual and allowable cost plus inflation, whichever is less.

(3) The rates may be adjusted if a new service is added after June 30, 2008. The initial reimbursement rate for the 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 rules 441—182.3(234) and 441—182.4(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.

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.

150.7(1) *Contract development.* The service area manager or designee shall assist the donor in completion of the contract document.

a. Contract approval or rejection. Before a contract can be effective it shall be signed by the following persons within the time frames provided:

(1) Donor or the donor's authorized representative.

(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 two weeks from receipt.

b. Contract effective date. The contract is effective upon signature of the chief of the bureau of purchased services.

c. Contract ending date. The contract ending date shall be specified in the contract, but shall not be later than June 30 following the effective date of the contract.

150.7(2) *Contract administration.*

a. Contract management. During the contract period the service area manager or designee shall be the liaison between the department and the donor. The liaison shall be contacted on all interpretations and problems relating to the contract. When a problem involves a particular service or administrative support contract, the project manager for that contract shall be notified by the liaison for the donor, if the project manager is not also the liaison.

b. Contract amendment. The contract shall be amended if:

(1) The donor or department is unable to comply with the existing terms of the contract and contract termination is not being sought.

(2) The donor decides to provide additional funds and the department agrees to accept them.

c. Contract termination. The contract may be terminated early if any of the following conditions exist:

(1) The donor and the department agree to terminate the contract early.

(2) The donor or the department fails to comply with contract terms.

d. Contract renewal. A donation of funds contract cannot be renewed. A new contract shall be negotiated when the donor wishes to provide funds in subsequent periods.

150.7(3) *Conditions of participation.*

a. Signed contract. A contract shall be effective only when signed by all parties required in 150.7(1)*"a."*

b. Civil rights laws. The donors 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.

c. Title VI compliance. The donors 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.

d. Section 504 compliance. The donors 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.

e. Affirmative action. The donors 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.

f. Confidentiality. The donor shall comply with all applicable federal and state laws and regulations on confidentiality.

g. Eligibility of clients for programs. Clients for whom services are purchased using funds donated through this contract must be determined eligible by the department using 441—Chapters 130 and 153.

h. Purchase of service system. The donor shall follow the policies of the purchase of service system established by the department.

i. Restrictions on donated funds. The donor may specify the geographical area to be served and the service to be provided.

j. Transmittal of funds. Any funds available under this contract shall be transmitted to the department at least quarterly. When funds are for match purposes, they shall be transmitted in amounts sufficient to cover the anticipated quarterly expenditures.

k. Accounting. The department shall supply a monthly report which provides an accounting of the use of the funds to the donor.

150.7(4) *Administrative control of funds.* Except for restrictions permitted by subrule 150.7(3)*"i,"* all donated 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.

150.7(5) *Reversion of unspent funds.* No funds donated and transmitted to the department will be returned to the donor unless the donor is a public agency. Unspent funds will be returned to the public agency donor after the contract period upon submittal of a written request to the chief of the bureau of purchased services.

441—150.8(234) Provider advisory committee. The provider advisory committee serves in an advisory capacity to the department, specifically to the bureau of purchased services. The provider advisory committee is composed of representatives from member provider associations as appointed by the respective associations. Individual representatives from provider agencies having a purchase of service contract but not belonging to an association may become members of the provider advisory committee upon simple majority vote of the committee members at a meeting. A representative of the purchase of service fiscal consultant is a nonvoting member. Departmental representatives from the bureau of purchased services, the office of the deputy director of field operations, the division of adult, children and families services, and the division of mental health and developmental disabilities are also nonvoting members.

441—150.9(234) Public access to contracts. Subject to applicable federal and state laws and regulations on confidentiality including 441—Chapter 9, all material submitted to the department of human services pursuant to this chapter shall be considered public information.

These rules are intended to implement Iowa Code section 234.6 and 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
[Rescinded IAB 4/4/01, effective 7/1/01]

[Filed 2/25/77, Notice 6/14/76—published 3/23/77, effective 4/27/77]
[Filed 9/28/77, Notice 8/10/77—published 10/19/77, effective 11/23/77]
[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 3/15/78]
[Filed emergency 2/28/78—published 3/22/78, effective 4/1/78]
[Filed 5/24/78, Notice 3/22/78—published 6/14/78, effective 7/19/78]
[Filed 9/23/82, Notice 8/4/82—published 10/13/82, effective 11/17/82]
[Filed 3/25/83, Notice 9/1/82—published 4/13/83, effective 7/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 3/1/84]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 9/7/84, Notice 7/4/84—published 9/26/84, effective 11/1/84]
[Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed emergency 3/21/86 after Notice 11/6/85—published 4/9/86, effective 4/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 12/22/86, Notice 10/22/86—published 1/14/87, effective 3/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed 11/25/87, Notice 9/23/87—published 12/16/87, effective 2/1/88]
[Filed emergency 4/22/88 after Notice 3/9/88—published 5/18/88, effective 5/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 12/8/88, Notice 7/13/88—published 12/28/88, effective 2/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed emergency 8/8/91—published 9/4/91, effective 9/1/91]
[Filed without Notice 8/8/91—published 9/4/91, effective 11/1/91]
[Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed 10/10/91, Notice 9/4/91—published 10/30/91, effective 1/1/92]

[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 1/14/93, Notice 12/9/92—published 2/3/93, effective 4/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 12/15/94, Notices 7/6/94, 10/12/94—published 1/4/95, effective 3/1/95]
[Filed 4/13/95, Notice 2/15/95—published 5/10/95, effective 7/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 9/13/99, Notice 7/28/99—published 10/6/99, effective 12/1/99]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed 3/14/01, Notice 1/24/01—published 4/4/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed emergency 7/11/01—published 8/8/01, effective 7/11/01]
[Filed 10/10/01, Notices 7/11/01, 8/8/01—published 10/31/01, effective 1/1/02]
[Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
[Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed 10/21/05, Notices 5/11/05, 6/8/05—published 11/9/05, effective 12/14/05]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]
[Filed 7/12/07, Notice 5/9/07—published 8/1/07, effective 9/5/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

[1] Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

CHAPTER 156
PAYMENTS FOR FOSTER CARE AND FOSTER PARENT TRAINING

[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.

"Basic family foster care" means the 24-hour care and supervision of a child provided by a licensed foster family. It includes the provision of food, lodging, clothing, shelter, support, ordinary transportation, recreation, and training which is appropriate for the child's age, mental, and physical capacity. It also includes assisting and contributing to the creation and updating of a child's lifebook and personal history, as well as assisting the child in maintaining cultural and ethnic connections.

"Basic maintenance payment" means the monthly reimbursement paid to foster parents for providing basic family foster care. The payment is based on the schedule found in subrule 156.6(l).

"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 of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and supervised apartment living services, when provided directly by the department caseworker rather than purchased from a provider, 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 foster family supervision and 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.

"Difficulty of care maintenance payment" means a monthly payment made, in addition to the basic maintenance payment, to foster parents providing care to a special needs child to cover the extra expenses, care and supervision, associated with the child's special needs.

"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.

"Emergency foster family care" means a foster care placement in a licensed foster home in which the family is willing to accept children with less than 24-hour notice. These placements are intended to be limited to 30 days or less, although some placements may extend longer. The emergency maintenance payment is based on the schedule found in rule 441—156.11(234).

"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 or private agency caseworkers to children in family foster care which is 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 less than 20 days. 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 in a single family living unit licensed by the department according to 441—Chapter 113 or licensed or approved by the state in which it is located.

"Foster family home study" means the initial written report and the annual update containing documentation of the family's compliance with 441—Chapter 113, an assessment of the family's ability to provide foster care, and a licensing recommendation.

"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 the same as defined in rule 441—24.61(225C,230A).

"Mentally retarded" means a child meeting the definition in Iowa Code section 222.2(5).

"Mental retardation professional" means the same as defined in the department of inspections and appeals subrule 481—57.1(15).

"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.

"Personal allowance" means the family investment program schedule of living costs for the areas of food, clothing, personal care and supplies, medicine chest items and communications as defined in 441—subrules 41.8(2) and 41.28(2).

"Physician" means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

"Required school fees" means fees required for the participation in school or extracurricular activities and fees related to enrolling a child in preschool when a mental health or mental retardation professional has recommended school attendance.

"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 one or more of the following conditions:

1. The child has been diagnosed by a physician to have a disability which substantially limits one or more major life activities; and requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified mental retardation professional to have mental retardation.
3. The child has been diagnosed by a qualified mental health professional to have a psychiatric condition which impairs the child's mental, intellectual, or social functioning.
4. The child has been diagnosed by a qualified mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior, which deviates substantially from behavior appropriate to the child's age or which significantly interferes with the child's intellectual, social, or personal adjustment.
5. The child has been diagnosed by a qualified medical professional, mental health professional, or substance abuse treatment supervisor as having a substance abuse problem.
6. The child is an unaccompanied refugee minor.
7. The child has been adjudicated delinquent.
8. The child has been diagnosed as HIV-infected or has had an HIV-positive test result by a qualified medical professional.

"Substance abuse treatment supervisor" means the same as defined in the substance abuse commission rule 643—3.1(125) as treatment supervisor.

"Unearned income" means any income which is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

441—156.2(234) Foster care recovery. The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

156.2(1) Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department shall serve as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall be made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(252C) Computation and assessment of parental liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.4(252C) Redetermination of liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.5(252C) Voluntary payment. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.6(234) Rate of maintenance payment for foster family care.

156.6(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule:

Age of child	Daily rate
0 through 5	$16.36
6 through 11	$17.01
12 through 15	$18.62
16 or over	$18.87

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 $5 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $10 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $15 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 maintenance payments to foster families supervised by the department or a licensed private child caring agency shall be made directly to the foster family by the department.

156.6(6) *Compliance transition period.* Rescinded IAB 6/9/93, effective 8/1/93.

This rule is intended to implement Iowa Code section 234.38.

441—156.7(234) Purchase of family foster care services.

156.7(1) *Types of services.* Rescinded IAB 4/11/07, effective 7/1/07.

156.7(2) *Family foster care supervision.* Purchased family foster care supervision shall meet the following requirements:

a. Services shall be provided in accordance with rule 441—108.7(234) and shall include visits with the child and foster family at a minimum frequency of not less than one visit every 35 days.

b. Services shall:

(1) Occur on a face-to-face basis.

(2) Be directed toward the child and shall include the child or the foster family.

(3) Be delivered in whatever locations the referral worker's social casework findings indicate are appropriate to ensure that all reasonable efforts are being made to meet the child's needs.

c. The department shall determine when to refer a child to a private agency for family foster care supervision and shall specify the maximum number of units and the duration of services authorized on Form 470-3055, Referral and Authorization for Child Welfare Services.

d. Units of service shall be provided in one-half hour increments.

e. Services shall be reimbursed for each billable unit of family foster care supervision authorized and delivered. The unit rate shall be determined according to the policies in rules 441—185.101(234) to 441—185.108(234).

f. The provider shall develop a service plan which meets the following requirements:

(1) The provider shall develop a service plan for each child receiving supervision services. The service plan shall be developed in collaboration with the referral worker, family, child, and foster parents unless the service plan contains documentation of the rationale for not involving one of these parties.

(2) Service plans shall be developed within 30 calendar days of initiating services. The provider shall document the dates and content of any collaboration on the service plan.

(3) Service plans shall describe the supervision service goals and objectives, the supervision services to be provided, and persons responsible for providing the supervision services.

(4) Each service plan shall identify the individual who will monitor the supervision services being provided to ensure that they continue to be necessary and consistent with the case permanency plan developed or modified by the referral worker.

(5) Each service plan shall be reviewed 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of supervision services or when any changes to the case permanency plan are made. The person reviewing the plan shall sign and date each review. If the review determines that the service plan is inconsistent with the case permanency plan, the provider's service plan shall be revised to reflect case permanency plan expectations.

(6) The provider shall provide a copy of all service plans and plan reviews to the family and referral worker, unless otherwise ordered by the court.

g. The provider shall receive approval from the referral worker on Form 470-3055, Referral and Authorization for Child Welfare Services, before increasing the amount or duration of services beyond what was previously approved. Based on their ongoing assessment activities, providers may communicate family service needs they believe are not adequately addressed in the department case permanency plan at any time during their provision of services.

h. The provider shall prepare a written report of termination activities which identifies the reason for termination, date of termination, and the recommended action or referrals upon termination.

i. The provider shall maintain a confidential individual record for each child receiving supervision services. The record shall include the following:

(1) Case permanency plan as supplied by the referral worker.

(2) Documentation of billed services which shall include: the specific services rendered, the date and amount of time services were rendered, who rendered the services, the setting in which services were rendered, and updates describing the client's progress.

(3) All service plans and service plan reviews developed by the agency.

(4) Correspondence with the referral worker regarding changes in the case permanency plan or service plan or requests for approval of additional services and any relevant evaluation activities.

(5) Progress reports 90 calendar days after initiating services and every 90 calendar days thereafter which summarize progress and problems in achieving the goals and objectives of the service plan. The progress report shall be written in conjunction with the service plan review and shall be completed no more than 15 calendar days before the report is due or 15 calendar days after the report is due. The provider shall provide a copy of all detailed progress reports to the family and referral worker, unless otherwise ordered by the court.

(6) Termination reports.

(7) Additional reports if requested by the referral worker.

(8) Form 470-3055, Referral and Authorization for Child Welfare Services.

156.7(3) *Family foster care treatment services.* Rescinded IAB 11/8/06, effective 11/1/06.

156.7(4) *Foster family home studies.* Rescinded IAB 4/11/07, effective 7/1/07.

156.7(5) *Purchasing services for individual children.* Rescinded IAB 4/11/07, effective 7/1/07.

156.7(6) *Billing procedures.* Billings shall be prepared and submitted pursuant to rule 441—185.121(234).

441—156.8(234) Special needs.

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 $250, to purchase clothing.

A second clothing allowance, not to exceed $200 for family foster care and $100 for all other levels, may be approved, not more than once within a calendar year, by the worker when a child in foster care needs clothing to replace lost clothing or because of unusual growth or weight change, and the child does not have escrow funds.

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 exceeding $5 may be authorized by the worker in an amount not to exceed $50 per calendar year if the child does not have escrow funds.

156.8(7) *Respite care.* The service area manager 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, with the exception of paragraphs 156.6(4)*"b"* and *"c."*

a. to *c.* Rescinded IAB 11/8/06, effective 11/1/06.

156.8(8) *Tangible goods, child care, and ancillary services.* To the extent that a child's escrow funds are not available, the service area manager 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.

Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

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.

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. If the Iowa Medicaid enterprise has not made a determination by October 31, 2006, on the need for remedial services for a child who is in group care placement as of that date, the department service area manager may approve a payment from state funds for the estimated daily reimbursement rate for remedial services that was used in the calculation of the provider's reimbursement rate under paragraph 156.9(1)*"c."* The service area manager shall document the reason for the delay in the decision on the child's need for remedial services.

(1) The service area manager may approve such payment only until the time that the Iowa Medicaid enterprise is anticipated to issue the decision regarding the child's need for remedial services. The service area manager shall not authorize payment from state funds if the Iowa Medicaid enterprise has determined that the child does not need remedial services.

(2) The payment that the service area manager may authorize shall be based on a reimbursement rate calculated as follows:

Step 1. Annualize the provider's 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.

Step 2. 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.

Step 3. Add the amounts determined in Steps 1 and 2.

Step 4. Determine the provider's estimated daily rate for reimbursement of remedial services by dividing the amount in Step 3 by 365 days.

EXAMPLE: Provider B has the following rates as of October 31, 2006:

- 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. $20.40 × 365 days = $7,446.00

Step 2. $79.68 × 52 weeks = $4,143.36

Step 3. $7,446.00 + $4,143.36 = $11,589.36

Step 4. $11,589.36 ÷ 365 days = $31.75 estimated daily rate for remedial services

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 cost principles in rules 441—185.101(234) to 441—185.108(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 rules 441—185.101(234) to 441—185.108(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.

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 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) In cases supervised by a private agency, the agency shall notify the worker of each visit and its planned length prior to the visit.

(4) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(5) 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.

(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) In cases supervised by a private agency, the agency 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 foster family home for hospitalization when the absence is in accord with the following:

(1) In cases supervised by a private agency, the agency shall notify 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 foster family shall be for the child to return to the foster family home after the hospitalization.

(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.

(7) In cases supervised by a private agency, the agency 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 foster family home after the child has run away when the absence is in accord with the following:

(1) In cases supervised directly by the department, the foster family shall notify the worker within 24 hours after the child runs away. In cases supervised by a private agency, the agency 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.

(7) In cases supervised by a private agency, the agency 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 foster family home shall be for the child to return to the foster family home.

(3) Staff from the foster family home shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) If services are purchased, 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(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.

441—156.11(234) Emergency care. Each service area shall have facilities to provide 24-hour emergency foster care. Emergency care shall not exceed 30 days in one six-month period, and the facility's policy may limit placement to less than 30 days. The following options shall be available for funding emergency care for each service area:

156.11(1) Foster family homes designated to maintain beds for emergency care shall be paid according to rule 156.6(234). In order to assure that there are adequate emergency beds available, designated homes may be paid a subsidy of $50 per month per bed. No emergency care facility shall be approved for more than five beds under subsidy.

156.11(2) Foster family home payment. Foster family homes may be designated to provide emergency care and may be paid on a daily rate per child when a child is placed. Rates for children shall be:

Age of Child	Rate
Age 0-11	$20.09 per day
Age 12 and over	$21.84 per day

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.

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 made pursuant to the basic daily maintenance rate for a child aged 16 and over in subrule 156.6(1). The maximum monthly payment shall be computed by multiplying the daily rate in subrule 156.6(1) by 365 and dividing by 12. 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.

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) Adoptive homes. Payment for foster care for a child placed in an adoptive home will only be made when the placement is made in anticipation of a subsidized adoption. The payment shall be limited to the amount anticipated for subsidy, and shall terminate when the adoption decree is granted.

This rule is intended to implement Iowa Code section 234.38.

441—156.18(237) Foster parent training expenses.

156.18(1) *Preservice training and orientation.* Each prospective foster family and provisionally licensed foster family who completes the required preservice training program and is issued a foster home license shall receive a $100 stipend from the department. The stipend shall be issued on or after the date that the license is issued. No expense stipend is provided for orientation.

156.18(2) *Required orientation.* Rescinded IAB 1/5/94, effective 3/1/94.

156.18(3) *Foster parent and social worker trainers.* Foster parents and social workers who serve as trainers for approved preservice training programs shall each be paid a contract fee per class hour appropriate to community standards based on the education and experience of each trainer. These rates shall be negotiated between the entity that contracts with the department and the trainer.

156.18(4) *In-service training.* Each licensed foster family who completes the in-service training requirement shall receive a $100 stipend from the department when the family's license is renewed, for per diem expenses related to meeting the in-service training requirement.

156.18(5) *Funds to association.* The department may provide funds to the Iowa foster and adoptive parent association for the following purposes:

a. Publication of educational articles in the association newsletter.

b. Financial assistance for foster parents who attend the National Foster Parent Association's annual conference.

c. Financial assistance for foster parents who attend the state association's annual conference.

156.18(6) *Foster parent training enhancement.* Rescinded IAB 12/11/02, effective 2/1/03.

156.18(7) *Transition.* Rescinded IAB 10/31/90, effective 1/1/91.

This rule is intended to implement Iowa Code section 237.5A.

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.* Except for payments for foster parents or youth in supervised apartment living, payment shall be limited to providers with a purchase of service contract in force. Providers of group care services shall have a purchase of rehabilitative treatment and supportive services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

[Filed 7/1/74; amended 9/4/74]
[Filed emergency 10/31/75—published 11/17/75, effective 11/1/75]
[Filed 12/23/75, Notice 11/17/75—published 1/12/76, effective 2/16/76]
[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]
[Filed emergency 7/29/76—published 8/23/76, effective 9/1/76]
[Filed 10/7/76, Notice 8/23/76—published 11/3/76, effective 12/8/76]
[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]
[Filed 5/24/78, Notice 3/22/78—published 6/14/78, effective 7/19/78]
[Filed emergency 7/28/78—published 8/23/78, effective 8/1/78]

[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed 10/24/80, Notice 9/3/80—published 11/12/80, effective 12/17/80]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]
[Filed emergency 8/20/82—published 9/15/82, effective 9/1/82]
[Filed 2/25/83, Notice 12/22/82—published 3/16/83, effective 5/1/83]
[Filed emergency after Notice 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed emergency 11/16/84—published 12/5/84, effective 12/1/84]
[Filed 1/21/85, Notice 12/5/84—published 2/13/85, effective 4/1/85]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 12/12/85, Notice 10/9/85—published 1/1/86, effective 3/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]◊
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]◊
[Filed emergency 9/21/87—published 10/21/87, effective 9/22/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 4/13/89, Notice 1/11/89—published 5/3/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/13/89, Notice 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
[Filed 11/15/91, Notice 9/18/91—published 12/11/91, effective 2/1/92]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 5/14/93, Notice 3/17/93—published 6/9/93, effective 8/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notice 2/17/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 1/1/94]
[Filed emergency 10/14/93—published 11/10/93, effective 11/1/93]
[Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
[Filed 12/16/93, Notices 10/13/93, 11/10/93—published 1/5/94, effective 3/1/94]
[Filed emergency 5/11/94 after Notice 3/16/94—published 6/8/94, effective 6/1/94]

[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
[Filed emergency 12/15/94—published 1/4/95, effective 2/1/95]
[Filed 12/15/94, Notice 10/26/94—published 1/4/95, effective 3/1/95]
[Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 3/20/95, Notice 1/18/95—published 4/12/95, effective 6/1/95]
[Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed emergency 7/12/95—published 8/2/95, effective 9/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 9/25/95, Notice 8/2/95—published 10/11/95, effective 12/1/95]
[Filed 2/14/96, Notice 12/20/95—published 3/13/96, effective 5/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 8/1/96]
[Filed 8/15/96, Notices 6/19/96, 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/17/96—published 10/9/96, effective 12/1/96]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 8/13/97, Notice 7/2/97—published 9/10/97, effective 11/1/97]
[Filed 10/15/97, Notice 7/30/97—published 11/5/97, effective 1/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed emergency 10/14/98 after Notice 8/26/98—published 11/4/98, effective 11/1/98]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed emergency 10/13/99 after Notice 8/25/99—published 11/3/99, effective 11/1/99]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed 1/10/01, Notice 11/15/00—published 2/7/01, effective 4/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
[Filed 11/18/02, Notice 8/21/02—published 12/11/02, effective 2/1/03]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]◊
[Filed 9/19/06, Notices 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 10/12/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06 after Notice 11/8/06—published 1/3/07, effective 1/1/07]
[Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

◊ Two or more ARCs

1 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

CHAPTER 168
CHILD CARE EXPANSION PROGRAMS
[Prior to 6/28/89, see 441—Chapter 154]

PREAMBLE

These rules define and structure funding for wrap-around child care programs and expansion of school-age child care programs. The purpose of wrap-around funding is to provide continuity of services for children through programs that support core programs by expanding the day and continuing the services through breaks in the core program schedule. School-age expansion funding is intended to increase access to child care for school-age children before and after school.

441—168.1(234) Definitions.

"Administrator" means the administrator of the department's division of children and family services.

"Applicant" means any eligible entity that submits a proposal.

"Child care facility," for the purposes of this chapter, means a facility that is licensed or that has a license in process under Iowa Code chapter 237A or a child care program established by a school pursuant to Iowa Code section 279.49.

"Contractor" means the entity with which the department contracts for administration of child care expansion program funds.

"Core program" means a Head Start program, an Early Head Start program, a department of education at-risk program, a Title I preschool, an Even Start program, or an early childhood special education program.

"Department" means the Iowa department of human services.

"Director" means the director of the department of human services.

"Proposal review committee" means a committee appointed by the chief of the department's bureau of child care and community services to review proposals and make recommendations to the department.

"School-age child care program" means a program that provides child care to children who are between five years of age and 13 years of age by September 15 and who are enrolled in a public or approved nonpublic school program.

"School-age expansion funding" means funding that assists in meeting expansion needs for school-age child care programs. School-age expansion funds shall increase access to school-age child care for children before and after school and during the summer and other breaks in the regular school schedule.

"Wrap-around child care program" means a program that provides child care for children before and after a core program and during the summer and other breaks in the core program schedule. Wrap-around child care programs shall provide continuity of services for children who attend an eligible core program and whose families meet the eligibility guidelines for child care assistance as set forth in rule 441—170.2(237A,239B).

441—168.2(234) Availability of funds.

168.2(1) In any year in which funds are available for wrap-around child care programs or for both wrap-around child care programs and school-age child care expansion, the department shall administer awards to eligible applicants based on:

a. The availability of funds;

b. The applicant's history and demonstration of quality of services provided; and

c. The applicant's compliance with department requirements.

168.2(2) If sufficient eligible proposals are not received or available, the department reserves the right not to allocate all funds.

441—168.3(234) Eligibility requirements.

168.3(1) *Wrap-around child care funding.* Funds shall be awarded to entities administering child care programs that provide continuity of services with a core program as defined in this chapter. Collaborative proposals within communities are encouraged.

a. All wrap-around program slots shall be reserved for children:

(1) Who attend a core program; and

(2) Whose families meet the eligibility guidelines for child care assistance as set forth in rule 441—170.2(237A,239B) at the time of enrollment for each contract year.

b. Wrap-around child care funds shall be used to support costs of the child care provided before and after the core program, including summer and other breaks in the core program schedule, for one service period as specified in the contract.

c. Child care assistance funds shall not be used for a child during the time the child is attending a wrap-around child care program.

168.3(2) *School-age expansion funding.* Funds may be awarded to entities that administer a school-age child care program as defined in this chapter if the applicant shows that the funds will increase the number of school-age children served or will expand participation of school-age children with special needs.

441—168.4(234) Request for proposals. The department shall announce the request for proposal period through public notice.

168.4(1) *Proposal submittal.* All applicants shall submit proposals to: Iowa Department of Human Services, Bureau of Child Care and Community Services, Hoover State Office Building, Fifth Floor, 1305 E. Walnut St., Des Moines, Iowa 50319-0114.

a. Proposals shall be in the form prescribed by the department.

b. To be eligible for review, the proposals shall be received by the due date specified in the request for proposals.

168.4(2) *Proposal requirements.* Requirements for proposals shall be specified in each request for proposals. A proposal that does not contain the information specified may be disqualified at the discretion of the department. Proposals shall describe how the program will improve services to children and shall include but not be limited to the following information:

a. Program description, including but not limited to:

(1) Stated goals and objectives of the program.
(2) Impact of proposal on children, families, and core program.
(3) Facility plan.
(4) Curriculum plan.
(5) Positive guidance plan.
(6) Health and safety plan.
(7) Food and nutrition plan.
(8) Evidence of an inclusive environment.
(9) Continuity of services plan.
(10) Staff plan.
(11) Professional development plan.
(12) Parental involvement plan.

b. Needs assessment:

(1) Geographical area to be served, including population density.
(2) Demographics of the service population.
(3) Socioeconomic data for the area served, such as indicators of poverty and teen pregnancy.

c. Description of community linkages and community collaboration.

d. Evidence of program quality and sustainability.

e. Proposed budget for the requested contract funds.

f. Evidence of required insurance coverage.

g. Other information identified in the request for proposals.

441—168.5(234) Selection of proposals. The administrator shall make the funding decisions.

168.5(1) *Review.* The department shall conduct a preliminary review of each proposal to ensure that the proposal is eligible for review by the proposal review committee. All eligible proposals received by the department shall be evaluated by the proposal review committee, which shall make funding recommendations to the administrator.

168.5(2) *Criteria.* The selection criteria shall be set forth in the request for proposals.

168.5(3) *Notice of decision.* Each applicant shall be notified within 60 days after the proposal due date whether the proposal has been denied or approved for funding and the amount of funds approved for the contract.

441—168.6(234) Appeals. Applicants dissatisfied with the department's decision may file a written appeal with the director. An appeal of a decision shall not stay contract negotiations with the apparent successful bidders.

168.6(1) The appeal must:

a. Be received within five working days of the date of the notice of decision;

b. Be based on a contention that the process:

(1) Was conducted outside of statutory authority;

(2) Violated state or federal law, policy, or rules;

(3) Did not provide adequate public notice;

(4) Was altered without adequate public notice; or

(5) Involved a conflict of interest by staff or committee members.

c. Include a request for the director to review the decision.

d. Include the reasons for the applicant's dissatisfaction.

168.6(2) Within ten working days of receipt of the appeal, the director shall review the appeal request and issue a final decision. An evidentiary hearing will not be conducted.

441—168.7(234) Contracts.

168.7(1) Before entering into a contract, the department may require modification of the program or budget, submission of further information or documents, or other stipulation of the applicant. The required modification, information, document, or stipulation shall be specified in the notification of contract award.

168.7(2) The department shall pay the contractor semiannually. The first payment shall be made after all parties have signed the contract. The second payment shall be made after the department has received, reviewed and approved the contractor's semiannual expenditure and performance report, as required in the contract. The contractor shall spend the funds only in accordance with the proposal approved by the department and as set forth in the contract.

168.7(3) The contractor shall keep records to document all services provided, as set forth in the contract. All records pertaining to programs funded by the contract shall be made available to the department upon request.

168.7(4) As specified in the contract, the contractor shall return unspent funds to the department with the submission of the final reports. Following the department review of the reports and contract delivery assessment, the department will determine if additional funds shall be returned.

168.7(5) Nothing in these rules shall be construed as limiting the remedies available to the state or the department for improper use of contract funds or other breach of the contractor's duties under the contract and applicable law.

441—168.8(234) Reporting requirements. Each contractor shall provide specified documents and information to the department to enable the department to evaluate the contractor, to monitor fiscal activity, and to ensure that the program goals are met.

168.8(1) The contractor shall submit expenditure reports at such times and in a format prescribed by the department as described in the contract.

168.8(2) The contractor shall submit performance reports at such times and in a format prescribed by the department as described in the contract.

168.8(3) Failure to submit a report by the due date shall result in suspension of department payment to the contractor until the report is received and approved. Delinquent or inadequate reports may negatively affect contracts or renewals for the following year.

168.8(4) The department may make monitoring visits to evaluate program management, fiscal accountability, and service delivery. The contractor shall receive a written report of the monitoring visit.

441—168.9(234) Termination of contract. Either party may terminate the contract at any time during the contract period by giving 60 days' notice to the other party.

168.9(1) The department may terminate a contract upon ten days' notice when the contractor fails to comply with the contract award stipulations, standards, or conditions.

168.9(2) Within 45 days of the termination of the contract, the contractor shall supply the department with a financial statement detailing all expenditures up to the effective date of the termination.

These rules are intended to implement Iowa Code section 234.6.

[Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
[Filed emergency 5/7/79—published 5/30/79, effective 5/7/79]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 4/25/84—published 7/4/84, effective 9/1/84]
[Filed 7/26/85, Notice 6/5/85—published 8/14/85, effective 10/1/85]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/26/87, Notice 1/28/87—published 4/22/87, effective 6/1/87]
[Filed 9/21/88, Notice 8/10/88—published 10/19/88, effective 12/1/88]
[Filed emergency 6/8/89—published 6/28/89, effective 7/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 6/14/90—published 7/11/90, effective 7/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed emergency 3/12/92—published 4/1/92, effective 3/12/92]
[Filed 5/14/92, Notice 4/1/92—published 6/10/92, effective 8/1/92]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]
[Filed 6/12/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]

TITLE XV
INDIVIDUAL AND FAMILY SUPPORT AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, a nonregistered family child care home, or in a facility exempt from licensing or registration.

441—170.1(237A) Definitions.

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

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

"Child care" means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

"Child with protective needs" means a child who has a case plan that identifies protective child care as a required service and who is a member of a family with one of the following:

1. A confirmed case of child abuse.
2. Episodes of family or domestic violence or substance abuse which place the child at risk of abuse or neglect and have resulted in a service referral to family preservation or family-centered services.

"Child with special needs" means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified mental retardation professional to have a condition which impairs the child's intellectual and social functioning.
3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

"Client" means a current or former recipient of the child care assistance program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;

2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;

3. Failure to timely report the receipt of child care units in excess of the number approved by the department;

4. Failure to comply with the need for service requirements.

"Department" means the Iowa department of human services.

"Food services" means the preparation and serving of nutritionally balanced meals and snacks.

"Fraudulent means" means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

"In-home" means care which is provided within the child's own home.

"Migrant seasonal farm worker" means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.

2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.

3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

"Overpayment" means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

"Parent" means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

"Program and activities" means the daily schedule of experiences in a child care setting.

"PROMISE JOBS" means the department's training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93, Division II.

"Provider" means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, a nonregistered child care home, or a child care facility which is exempt from licensing or registration.

"Provider error" means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;

2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;

4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services.

"Recoupment" means the repayment of an overpayment by a payment from the client or provider or both.

"Relative" means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

"Supervision" means the care, protection, and guidance of a child.

"Transportation" means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

"Unit of service" means a half day which shall be up to 5 hours of service per 24-hour period.

"Vocational training or education" means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

1. Training may be approved for high school completion activities, adult basic education, GED, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

2. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time plans may be approved only if the number of credit hours to complete training is less than full-time status, the required prerequisite credits or remedial course work is less than full-time status, or training is not offered on a full-time basis.

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements

under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

170.2(1) *Financial eligibility.* Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa's median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. Income limits. For initial and ongoing eligibility, a family's nonexempt gross monthly income as established in paragraph 170.2(1)*"c"* cannot exceed:

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa's median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. Exceptions to income limits.

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. Determining gross income. In determining a family's gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)*"d."*

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation, workers' compensation, alimony, child support, and veterans pensions. "Net profit from self-employment" means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

d. Income exclusions. The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food Stamp Act of 1964.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under Title III, Part C—Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973.

(18) Stipends received for participating in the foster grandparent program.

(19) The first $65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

(27) Any adoption subsidy payments received from the department.

(28) Federal or state earned income tax credit.

(29) Payments from the Iowa individual assistance grant program (IIAGP).

(30) Payments from the transition to independence program (TIP).

(31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program. EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

(32) Reimbursement from the employer for job-related expenses.

(33) Stipends from the preparation for adult living (PAL) program.

(34) Payments from the subsidized guardianship waiver program.

e. Family size. The following people shall be included in the family size for the determination of eligibility:

(1) Legal spouses (including common law) who reside in the same household.

(2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.

(3) A child or children who live with a person or persons not legally responsible for the child's support.

f. Effect of temporary absence. The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

(1) An absence for the purpose of education or employment.

(2) An absence due to medical reasons that is anticipated to last less than three months.

(3) Any absence when the person intends to return home within three months.

170.2(2) *General eligibility requirements.* In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

a. Age. Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19.

b. Need for service. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending dates that fall within two calendar months but shall only count as one month. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the 24-month limit.

Payment shall not be approved for the following:

1. When labor market statistics for a local area indicate low employment potential. Exceptions may be made when the client has a job offer prior to entering the training or if a client is willing to relocate after training to an area where there is employment potential. Clients willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the client.

2. Jobs paying less than minimum wage.

3. College coursework for a client who possesses a baccalaureate degree unless the coursework is to obtain a teaching certificate or complete continuing education units.

4. The course or training is one that the client has previously completed.

5. When the client was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.

PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment of a single parent or the coinciding hours of employment of both parents in a two-parent home and for actual travel time between home, child care facility, and place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent needs child care as part of a protective service plan to prevent or alleviate child abuse or neglect.

(4) The person who normally cares for the child is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but is unable to care for the child, as verified by a physician. Care under this paragraph is limited to a maximum of one month, unless extenuating circumstances are justified and approved after case review by the service area manager or designee.

(5) The parent is looking for employment. Child care for job search shall be limited to only those hours the parent is actually looking for employment including travel time. A job search plan shall be approved by the department and limited to a maximum of 30 working days in a 12-month period. Child care in two-parent families may be provided only during the coinciding hours of both parents' looking for employment, or during one parent's employment and one parent's looking for employment. Documentation of job search contacts shall be furnished to the department. The department may enter into a nonfinancial coordination agreement for information exchange concerning job search documentation.

EXCEPTION: Additional hours may be paid for job search for PROMISE JOBS recipients if approved by the PROMISE JOBS worker.

(6) The person is participating in activities approved under the PROMISE JOBS program and there is a need for child care services.

(7) The family is part of the family investment program and there is a need for child care.

If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

c. Residency. To be eligible for child care services, the person must be living in the state of Iowa. "Living in the state" shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

d. Citizenship. As a condition of eligibility, the applicant shall attest to the child's citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0466, Health and Financial Support Application. Child care assistance payments may be made only for a child who:

(1) Is a citizen or national of the United States; or

(2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child's entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or

2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

e. Cooperation. Parents shall cooperate with the department when the department selects the family's case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family's child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

170.2(3) *Priority for assistance.* Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. Priority groups. As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members are employed at least 28 hours per week, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members are employed at least 28 hours per week.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

b. Exceptions to priority groups. The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2)*"b"* except at review or redetermination.

170.2(4) *Reporting changes.* The parent must report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported, the effective date of the change shall be the date when the change is reported to the department office or PROMISE JOBS office.

441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) *Application process.*

a. Application for child care assistance may be made at any local office of the department on:

(1) Form 470-3624 or 470-3624(S), Child Care Assistance Application, or

(2) Form 470-0462 or 470-0466, Health and Financial Support Application.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form is received in the county office.

d. Families who are determined eligible for child care assistance shall be approved for a certification period of no longer than six months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

170.3(2) *Exceptions to application requirement.* Applications are not required for:

a. A person who is participating in activities approved under the PROMISE JOBS program.

b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

c. Families with protective service needs.

d. Child care services provided under a court order.

170.3(3) *Application processing.* The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received.

a. The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and inform the family and the family's provider through the notice of decision.

b. The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility. EXCEPTION: When the court orders services, the court order provided by the court and the case plan provided by the department shall serve as written notification.

170.3(4) *Waiting lists for child care services.* When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

170.3(5) *Review and redetermination.* The department shall redetermine a family's financial and general eligibility for child care assistance at least every six months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP) and for those whose earned income was taken into account in determining the needs of FIP recipients, because these people are deemed financially eligible so long as the FIP eligibility continues.

a. If FIP eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

b. The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility. The department shall issue a notice of expiration for the child care assistance certification period in Form 470-4377 or 470-4377(S). If the family does not return the review form to the department by the end of the certification period, the family must reapply for benefits.

441—170.4(237A) Elements of service provision.

170.4(1) *Case plan.* The case plan shall be developed by the department service worker and contain information described in 441—subrule 130.7(2), when the child meets the need for service under 170.2(2)*"b"*(3).

170.4(2) *Fees.* Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

a. Sliding fee schedule. The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2008:

	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
Level	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
A	$824	$1,109	$1,394	$1,679	$1,964	$2,249	$2,534	$2,819	$3,104	$3,389	$0.00	$0.00	$0.00

	Monthly Income According to Family Size										Unit Fee Based on Number of Children in Care		
Level	1	2	3	4	5	6	7	8	9	10	1	2	3 or more
B	$867	$1,167	$1,467	$1,767	$2,067	$2,367	$2,667	$2,967	$3,267	$3,567	$0.20	$0.45	$0.70
C	$891	$1,200	$1,508	$1,816	$2,125	$2,433	$2,742	$3,050	$3,358	$3,667	$0.45	$0.70	$0.95
D	$916	$1,232	$1,549	$1,866	$2,183	$2,500	$2,816	$3,133	$3,450	$3,767	$0.70	$0.95	$1.20
E	$941	$1,267	$1,593	$1,918	$2,244	$2,570	$2,895	$3,221	$3,547	$3,872	$0.95	$1.20	$1.45
F	$967	$1,301	$1,636	$1,970	$2,305	$2,640	$2,974	$3,309	$3,643	$3,978	$1.20	$1.45	$1.70
G	$994	$1,338	$1,682	$2,026	$2,370	$2,713	$3,057	$3,401	$3,745	$4,089	$1.45	$1.70	$1.95
H	$1,021	$1,374	$1,728	$2,081	$2,434	$2,787	$3,141	$3,494	$3,847	$4,200	$1.70	$1.95	$2.20
I	$1,050	$1,413	$1,776	$2,139	$2,502	$2,865	$3,229	$3,592	$3,955	$4,318	$1.95	$2.20	$2.45
J	$1,078	$1,451	$1,824	$2,197	$2,570	$2,943	$3,316	$3,690	$4,063	$4,436	$2.20	$2.45	$2.70
K	$1,108	$1,492	$1,875	$2,259	$2,642	$3,026	$3,409	$3,793	$4,176	$4,560	$2.45	$2.70	$2.95
L	$1,139	$1,532	$1,926	$2,320	$2,714	$3,108	$3,502	$3,896	$4,290	$4,684	$2.70	$2.95	$3.20
M	$1,170	$1,575	$1,980	$2,385	$2,790	$3,195	$3,600	$4,005	$4,410	$4,815	$2.95	$3.20	$3.45
N	$1,202	$1,618	$2,034	$2,450	$2,866	$3,282	$3,698	$4,114	$4,530	$4,946	$3.20	$3.45	$3.70
O	$1,236	$1,664	$2,091	$2,519	$2,947	$3,374	$3,802	$4,230	$4,657	$5,085	$3.45	$3.70	$3.95
P	$1,270	$1,709	$2,148	$2,588	$3,027	$3,466	$3,905	$4,345	$4,784	$5,223	$3.70	$3.95	$4.20
Q	$1,305	$1,757	$2,208	$2,660	$3,112	$3,563	$4,015	$4,466	$4,918	$5,370	$3.95	$4.20	$4.45
R	$1,341	$1,805	$2,269	$2,732	$3,196	$3,660	$4,124	$4,588	$5,052	$5,516	$4.20	$4.45	$4.70
S	$1,378	$1,855	$2,332	$2,809	$3,286	$3,763	$4,240	$4,717	$5,193	$5,670	$4.45	$4.70	$4.95
T	$1,416	$1,906	$2,396	$2,885	$3,375	$3,865	$4,355	$4,845	$5,335	$5,825	$4.70	$4.95	$5.20
U	$1,455	$1,959	$2,463	$2,966	$3,470	$3,973	$4,477	$4,981	$5,484	$5,988	$4.95	$5.20	$5.45
V	$1,495	$2,012	$2,530	$3,047	$3,564	$4,082	$4,599	$5,116	$5,634	$6,151	$5.20	$5.45	$5.70
W	$1,537	$2,069	$2,601	$3,132	$3,664	$4,196	$4,728	$5,260	$5,791	$6,323	$5.45	$5.70	$5.95
X	$1,579	$2,125	$2,671	$3,218	$3,764	$4,310	$4,857	$5,403	$5,949	$6,495	$5.70	$5.95	$6.20
Y	$1,623	$2,185	$2,746	$3,308	$3,869	$4,431	$4,993	$5,554	$6,116	$6,677	$5.95	$6.20	$6.45
Z	$1,667	$2,244	$2,821	$3,398	$3,975	$4,552	$5,128	$5,705	$6,282	$6,859	$6.20	$6.45	$6.70
AA	$1,714	$2,307	$2,900	$3,493	$4,086	$4,679	$5,272	$5,865	$6,458	$7,051	$6.45	$6.70	$6.95
BB	$1,761	$2,370	$2,979	$3,588	$4,197	$4,807	$5,416	$6,025	$6,634	$7,243	$6.70	$6.95	$7.20

To use the chart:

(1) Find the family size used in determining income eligibility for service.

(2) Move across the monthly income table to the column headed by that number. (See subparagraph (5) if the family has more than ten members.)

(3) Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.

(4) Choose the fee that corresponds to the number of children in the family who receive child care assistance.

(5) When a family has more than ten members, determine the income level by multiplying the figures in the four-member column for the rows closest to the family's income level by 0.03. Round the numbers to the nearest dollar and multiply by the number of family members in excess of ten. Add the results to the amounts in the ten-member column to determine the threshold amounts.

EXAMPLES:

1. Family 1 has two members, monthly income of $1,100, and one child in care. Since the income is at or above the Level A amount but less than the Level B amount, Family 1 pays $0.00 for each unit of child care service that the child receives.

2. Family 2 has three members, monthly income of $1,450, and one child in care. Since the income is at or above the Level B amount but less than the Level C amount, Family 2 pays $0.20 for each unit of child care service that the child receives.

3. Family 3 has three members, monthly income of $1,450, and two children in care. The younger child receives ten units of child care service per week. The older child is school-aged and receives only five units of service per week. Since the income is at or above the Level B amount but less than the Level C amount, Family 3 pays $0.45 for each unit of child care service that the younger child receives.

b. Collection. The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

c. Inability of client to pay fees. Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

170.4(3) *Method of provision.* Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)*"b"*(3), as long as the conditions in paragraph 170.4(7)*"d"* are met. When the child meets the need for service under 170.2(2)*"b"*(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child.

The provider must meet one of the applicable requirements set forth below.

a. Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

b. Registered child development home. A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

c. Registered family child care home. Rescinded IAB 1/7/04, effective 3/1/04.

d. Relative care. Rescinded IAB 2/6/02, effective 4/1/02.

e. In-home care. The adult caretaker selected by the parent to provide care in the child's own home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

f. Nonregistered family child care home. The adult caretaker selected by the parent to provide care in a nonregistered family child care home shall be sent the pamphlet Comm. 95 or Comm. 95(S), Minimum Health and Safety Requirements for Nonregistered Child Care Home Providers, and Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered providers that include:

(1) Minimum health and safety requirements;

(2) Limits on the number of children for whom care may be provided;

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order; and

(4) Conditions that warrant nonpayment.

g. Exempt facilities. Child care facilities operated by or under contract to a public or nonpublic school accredited by the department of education that are exempt from licensing or registration may receive payment for child care services when selected by a parent.

h. Record checks for nonregistered family child care homes. If a nonregistered child care provider wishes to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form 470-0643, Request for Child Abuse Information, and Form 595-1489 or 595-1489(S), Non-Law Enforcement Record Check Request, Form A, for the provider, for anyone having access to a child when the child is alone, and for anyone 14 years of age or older living in the home. The department worker or the PROMISE JOBS worker shall provide the necessary forms. The provider shall return the forms to the department worker or PROMISE JOBS worker.

(1) If any of these individuals has a record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the department shall perform an evaluation following the process defined at 441—subrule 110.7(3).

(2) If any of the individuals would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant, and shall forward a copy of that notification to the county attorney, the department worker, and the PROMISE JOBS worker, if applicable.

(3) A person who continues to provide child care in violation of this law is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) *Components of service program.* Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) *Levels of service according to age.* Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) *Provider's individual program plan.* An individual program plan shall be developed by the child care provider for each child within 30 days after placement when the need for service was established under 170.2(2)*"b"*(3). The program plan shall be supportive of the service worker's case plan. The program plan shall contain goals, objectives, services to be provided, and time frames for review.

170.4(7) *Payment.* The department shall make payment for child care provided to eligible families when the provider has a completed Form 470-3871, Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker or PROMISE JOBS worker shall sign this form.

a. Rate of payment. The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)*"d,"* shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider and age group in Table I, except for special needs care which shall not exceed the rate applicable to the provider and age group in Table II. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for "child with special needs," and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

Table I
Half-Day Rate Ceilings for Basic Care

Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	$15.50	$12.00	$11.50	$8.19
Preschool	$12.50	$11.25	$11.25	$7.19
School Age	$11.25	$10.00	$10.00	$7.36

Table II Half-Day Rate Ceilings for Special Needs Care				
Age Group	Child Care Center	Child Development Home Category A or B	Child Development Home Category C	Nonregistered Family Home
Infant and Toddler	$48.00	$15.75	$12.38	$10.24
Preschool	$28.13	$14.63	$12.38	$ 8.99
School Age	$28.04	$13.50	$11.25	$ 9.20

The following definitions apply in the use of the rate tables:

(1) "Child care center" shall mean those providers as defined in 170.4(3)*"a"* and *"g."* "Registered child development home" shall mean those providers as defined in 170.4(3)*"b."* "Nonregistered family child care home" shall mean those providers as defined in 170.4(3)*"f."*

(2) Under age group, "infant and toddler" shall mean age two weeks to two years; "preschool" shall mean two years to school age; "school age" shall mean a child in attendance in full-day or half-day classes.

b. Payment for days of absence. Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

c. Payment for multiple children in a family. When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

d. Payment for in-home care. Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

e. Limitations on payment. Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

f. Review of the calculation of the rate of payment. Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7)*"a"* may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director's designee within 15 calendar days of the decision. The director or director's designee shall issue the final department decision within 15 calendar days of receipt of the request.

g. Submission of claims. The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay only for the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit either:

(1) Form 470-0020, Purchase of Services Provider Invoice, or Form 470-4466 or 470-4466(S), Child Care Provider Claim, accompanied by Form 470-3872, Child Care Assistance Attendance Sheet, signed by the parent; or

(2) Form 470-3896, PROMISE JOBS Child Care Attendance and Invoice.

441—170.5(237A) Adverse actions.

170.5(1) *Provider agreement.* The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871, if:

a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazards; or

b. The provider has submitted claims for payment for which the provider is not entitled; or

c. The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.

170.5(2) *Denial.* Child care assistance shall be denied when the department determines that:

a. The client is not in need of service; or

b. The client is not financially eligible; or

c. There is another community resource available to provide the service or a similar service free of charge; or

d. An application is required and the client or representative refuses or fails to sign the application form; or

e. Funding is not available; or

f. The client refuses or fails to supply documentation of eligibility as to need or income; or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(3) *Termination.* Child care assistance may be terminated when the department determines that:

a. The client no longer meets the eligibility criteria in subrule 170.2(2); or

b. The client's income exceeds the financial guidelines; or

c. The client refuses or fails to supply documentation of eligibility as to need and income; or

d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or

e. Another community resource is available to provide the service or a similar service free of charge; or

f. Funding is not available; or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(4) *Reduction.* Authorized units of service may be reduced when the department determines that:

a. Continued provision of service at the current level is not necessary to meet the client's service needs; or

b. Another community resource is available to provide the same or similar service free of charge that will meet the client's needs; or

c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

441—170.6(237A) Appeals. Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

441—170.7(237A) Provider fraud.

170.7(1) *Fraud.* The department shall consider a child care provider to have committed fraud when:

a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of $1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of $1,000.

170.7(2) *Potential sanctions.* Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

a. Special review of the provider's claims for child care assistance.

b. Suspension from receipt of child care assistance payment for six months.

c. Ineligibility to receive payment under child care assistance.

170.7(3) *Factors considered in determining level of sanction.* The department shall evaluate the following factors in determining the sanction to be imposed:

a. History of prior violations.

(1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.

(2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

b. Prior imposition of sanctions.

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

c. Seriousness of the violation.

(1) If the amount fraudulently received is less than $5,000, the sanction level shall be determined according to paragraphs *"a"* and *"b."*

(2) If the amount fraudulently received is $5,000 or more, and the sanction determined according to paragraphs *"a"* and *"b"* is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is $5,000 or more, and the sanction determined according to paragraphs *"a"* and *"b"* is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

d. Extent of the violation.

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs *"a"* and *"b."*

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs *"a"* and *"b"* is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs *"a"* and *"b"* is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

170.7(4) *Mitigating factors.*

a. If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

(1) Prior provision of provider education.

(2) Provider willingness to obey program rules.

b. If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph *"a"* indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

(1) Suspension from receipt of child care assistance payment for six months; and

(2) A special review of provider claims.

c. If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph *"a"* indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

441—170.8(234) Allocation of funds. Rescinded IAB 2/6/02, effective 4/1/02.

441—170.9(237A) Child care assistance overpayments. All child care assistance overpayments shall be subject to recoupment.

170.9(1) *Notification and appeals.* All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client's or provider's request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—subrule 7.5(9).

170.9(2) *Determination of overpayments.* All overpayments due to client, provider, or agency error or due to benefits or payments issued pending an appeal decision shall be recouped. Overpayments shall be computed as if the information had been acted upon timely.

170.9(3) *Benefits or payments issued pending appeal decision.* Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing shall not occur until after a final appeal decision is issued affirming the department.

170.9(4) *Failure to cooperate.* Failure by the client to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments shall result in payments being recouped for the months in question.

170.9(5) *Payment agreement.* The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to on the notification form issued pursuant to subrule 170.9(6). Failure to negotiate an approved payment agreement may result in further collection action as outlined in 441—Chapter 11.

170.9(6) *Procedures for recoupment.*

a. When the department determines that an overpayment exists, the department shall refer the case to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

b. The department of inspections and appeals shall initiate recoupment by notifying the debtor of the overpayment using one of the following forms:

(1) Form 470-3627, Demand Letter for Child Care Assistance Provider Error Overissuance; or

(2) Form 470-3628, Demand Letter for Child Care Assistance Agency Error Overissuance;

(3) Form 470-3807, Demand Letter for Child Care Assistance Client Error Benefit Overissuance; or

(4) Form 470-4530, Notice of Child Care Assistance Overpayment.

c. When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

d. Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

e. Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

170.9(7) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than $35. Recoupment will be waived on nonfraud overpayments of less than $35 which have been held in suspense for three years.

These rules are intended to implement Iowa Code sections 237A.13 and 237A.29.

[Filed 7/3/79, Notice 12/27/78—published 7/25/79, effective 9/1/79]
[Filed 7/18/80, Notice 3/5/80—published 8/6/80, effective 9/10/80]
[Filed 12/19/80, Notice 10/29/80—published 1/7/81, effective 2/11/81]
[Filed 1/16/81, Notice 12/10/80—published 2/4/81, effective 4/1/81]
[Filed 4/29/82, Notice 3/3/82—published 5/26/82, effective 7/1/82]
[Filed 5/21/82, Notice 3/31/82—published 6/9/82, effective 8/1/82]
[Filed emergency 9/23/82—published 10/13/82, effective 9/23/82]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed 1/15/87, Notice 12/3/86—published 2/11/87, effective 4/1/87]
[Filed 9/21/88, Notice 8/10/88—published 10/19/88, effective 12/1/88]
[Filed emergency 6/8/89 after Notice of 5/3/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/8/89—published 6/28/89, effective 7/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 10/10/91—published 10/30/91, effective 11/1/91]
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]

[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 10/14/93—published 11/10/93, effective 12/1/93]
[Filed 12/16/93, Notice 11/10/93—published 1/5/94, effective 3/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed emergency 7/10/96—published 7/31/96, effective 8/1/96]
[Filed 9/17/96, Notices 7/3/96, 7/31/96—published 10/9/96, effective 12/1/96]
[Filed 4/11/97, Notice 2/26/97—published 5/7/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 8/13/97, Notice 7/2/97—published 9/10/97, effective 11/1/97]
[Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
[Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]
[Filed 8/12/98, Notice 6/17/98—published 9/9/98, effective 11/1/98]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed 2/14/01, Notice 11/29/00—published 3/7/01, effective 5/1/01]
[Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 8/1/01]
[Filed 1/9/02, Notice 11/28/01—published 2/6/02, effective 4/1/02]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed 12/16/03, Notice 10/29/03—published 1/7/04, effective 3/1/04]
[Filed emergency 5/14/04—published 6/9/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/9/04—published 9/1/04, effective 10/6/04]
[Filed emergency 7/15/05—published 8/3/05, effective 9/1/05]
[Filed 10/21/05, Notice 8/3/05—published 11/9/05, effective 12/14/05]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed emergency 5/12/06—published 6/7/06, effective 7/1/06]
[Filed 10/20/06, Notice 8/30/06—published 11/8/06, effective 1/1/07]
[Filed 4/11/07, Notice 2/14/07—published 5/9/07, effective 7/1/07]
[Filed emergency 6/14/07—published 7/4/07, effective 7/1/07]
[Filed 6/13/07, Notice 4/11/07—published 7/4/07, effective 9/1/07]
[Filed emergency 9/12/07—published 10/10/07, effective 9/12/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
[Filed emergency 5/14/08—published 6/4/08, effective 7/1/08]
[Filed 5/16/08, Notice 3/26/08—published 6/18/08, effective 8/1/08]
[Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]

CHAPTER 171
ADULT DAY CARE
Rescinded IAB 3/6/02, effective 5/1/02

CHAPTER 185
REHABILITATIVE TREATMENT SERVICES

DIVISION I
GENERAL PROVISIONS

PREAMBLE

These rules define and structure the department of human services' rehabilitative treatment services program. Rehabilitative treatment services are designed to address the treatment needs of children and their families in the following four programs: family-centered services, family preservation, family foster care and group care.

These rules outline the application process, eligibility, service necessity determination and service authorization process, documentation requirements, service termination and appeal procedures, and establish service provision, rate-setting and payment mechanisms associated with rehabilitative treatment services. These rules also establish standards for provider certification, audits, and sanctions for providers. The provisions for rate setting are also applicable to supportive services as defined in this chapter.

441—185.1(234) Definitions.

"Adverse authorization action" means an authorization determination decreasing the requested scope, amount, or duration of services, or denying rehabilitative treatment services.

"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.

"Agency" means any entity, public or private, which provides or represents itself as providing rehabilitative treatment or supportive services.

"Amount" means the number of units of a service core or level of care within a rehabilitative treatment service.

"Authorization action" means an authorization determination approving rehabilitative treatment services.

"Authorized representative" within the context of rule 441—185.13(234) means that person appointed to carry out audit procedures, including assigned auditors, fiscal consultants, or agents contracted for specific audits or audit procedures.

"Behavioral management for children in therapeutic foster care" means services to design, assess, or revise therapeutic treatment strategies in therapeutic treatment family foster homes in order to meet the specific medical-behavioral health needs of children identified by a licensed practitioner of the healing arts. The focus of the service is to develop an intervention plan with the therapeutic treatment foster family to address the specific medical-behavioral health needs of the child, assess the effectiveness of the treatment strategies and interventions in measurable terms on an ongoing basis, and revise the treatment strategies when they are found not to be addressing the specific medical-behavioral condition of the child.

"Care plan" means the plan developed by the provider and treatment foster family for the interventions to be provided by the treatment foster family in accordance with the provider's treatment plan.

"Case permanency plan" shall mean the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved; and reviewing progress.

"Certification" means the decision made by the department that the provider has met the applicable standards.

"Certified psychiatric mental health nurse practitioner" means a person who meets the requirements of a certified psychiatric mental health nurse and is eligible for certification by the American Nursing Association and is licensed by the state of Iowa to practice nursing as defined in Iowa Code chapter 152.

"Child" means a person under 21 years of age.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that tells the amount of requested payment and the service rendered by a provider to a child and family.

"Clinical record" means a tangible and legible record which meets the criteria established for clinical records set forth in rule 441—185.10(234).

"Community residential setting" means a group care residential setting licensed as a community residential facility under 441—Chapter 114.

"Community residential setting for mentally retarded children" means a group care residential setting licensed as a community residential facility for children with mental retardation licensed under 441—Chapter 116.

"Comprehensive residential setting" means a group care residential setting licensed as a comprehensive residential facility under 441—Chapter 115.

"Comprehensive residential setting for mentally retarded children" means a facility licensed as a comprehensive residential facility for children with mental retardation under 441—Chapter 116.

"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.

"Deemed status" means an acceptance of an outside body's review, assessment, and accreditation of a rehabilitative treatment services provider's functioning and services in lieu of certification based on review and evaluation by the department.

"Department" means the Iowa department of human services.

"Department worker" means the worker who is responsible for providing social casework as described in 441—Chapter 131.

"Duration" means the maximum period of time for which the service core or level of care within rehabilitative treatment service is authorized.

"Enhanced residential treatment" means a treatment program in a facility licensed under 441—Chapter 115.

"Experience in the delivery of child welfare and juvenile justice services" means experience working with families at risk of child abuse, children at risk of delinquency, children who have been abused, children adjudicated CINA or delinquent, and children with emotional or behavioral disorders.

"Experience in the delivery of human services" means paid or volunteer experience providing social casework, therapy, or skill development services to children or families; supervision of children; as well as other experiences providing direct care to children and families. It does not include activities engaged in as part of a practicum or internship for academic credit.

"Extrapolation" means that the total amount of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive, or step mother or father, and children who reside in the same household.
3. A child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

"Family preservation" means treatment services provided in the family preservation program that have duration limited to 60 calendar days, but are expected to last an average of 45 calendar days.

"Family skill development" means services to train or educate parents on specific therapeutic interventions to enable them to meet the specific medical-behavioral health treatment needs of the child including guidance and interventions that address the specific medical-behavioral health needs of the child, techniques for caring for a child with special needs, and guidance and intervention to alleviate a pattern of impaired interactions associated with a specific medical-behavioral need of a child.

"Fiscal record" means a tangible and legible history which documents the criteria established for fiscal records as set forth in subrule 185.102(3).

"Generally accepted auditing procedures" means those procedures published in Standards for Audit of Governmental Organizations, Programs, Activities & Functions, 1988 Edition, by the Comptroller General of the United States.

"Highly structured juvenile program" means a treatment program for adjudicated delinquent youth, aged 15 to 17, licensed as either community residential facilities under 441—Chapter 114 or as comprehensive residential facilities under 441—Chapter 115.

"Imminent risk of placement" means that the family at issue includes one or more children considered by the referral worker to be either at high risk or immediate risk of placement. Cases considered at immediate or high risk of placement are defined as follows:

1. Immediate. Immediate-risk cases are those in which the referral worker has determined that a child needs to be placed out of home, at least one family member's safety is in immediate jeopardy, and either emergency placement procedures or emergency and intensive preventive services need to commence immediately.

2. High. High-risk cases are those in which the referral worker has determined that a child needs an out-of-home placement, but the family's condition is such that the immediate safety of any family member is not jeopardized. Nonemergency placement procedures would commence if some type of preventive services were not provided. These cases may include families already receiving preventive services but for whom the referral worker has determined client progress is such that a continuation of the nonfamily preservation services would not ensure family unity and self-sufficiency upon termination of the services.

"Individual provider" means a person who seeks certification pursuant to rule 441—185.10(234) or who is under contract pursuant to 441—Chapter 152 and who delivers rehabilitative treatment and supportive services independent of a partnership, corporation, agency, governmental unit or any other legal entity.

"Juvenile court officer (JCO)" means a person appointed as a juvenile court officer under Iowa Code chapter 602 and a chief juvenile court officer appointed under Iowa Code chapter 602.

"Level of care" means a level of treatment services within the group care program that is differentiated by the intensity of skill development and therapy services provided, the hours of awake supervision, and the ratio of skill development staff to child. There are four levels of rehabilitative treatment in the group care program:

1. Community residential.
2. Comprehensive residential.
3. Enhanced comprehensive residential.
4. Highly structured juvenile program.

"Licensed independent social worker" for purposes of this chapter means a person who is licensed as an independent social worker under Iowa Code chapter 154C in activities which are directed at enhancing or restoring people's capacity for social functioning, whether impaired by environmental, emotional, or physical factors, with particular attention to the person-in-situation configuration.

"Licensed practitioner of the healing arts" means one of the following who is licensed to practice in the state of Iowa as:

1. A psychologist.
2. A certified psychiatric mental health nurse practitioner.
3. A licensed independent social worker.
4. A marital and family therapist.
5. A mental health counselor.

"Marital and family therapist" means a person who is licensed to practice marital and family therapy in the state of Iowa pursuant to Iowa Code chapter 154D.

"Mental health counselor" means a person who is licensed to practice mental health counseling in the state of Iowa pursuant to Iowa Code chapter 154D.

"Nonprime programming time" means any period of the day in a group care program other than prime programming time and sleeping time.

"Nonrehabilitative treatment need" means the child and family have a protective, supportive or preventative need for which the child has no identified rehabilitative behavioral health treatment need. Services to address a nonrehabilitative treatment need may be directed at a family member to meet the child's safety, treatment, or permanency need.

"Nonrehabilitative treatment service" means a service to address the nonrehabilitative treatment need of a child. Nonrehabilitative treatment services are designed either to restore a skill or function or teach a new skill or function to achieve maximum independence and functioning. These services may also be directed toward family members to help them meet the treatment, safety, or permanency needs of a child. Nonrehabilitative treatment services are designed to meet treatment needs in one of the following programs:

1. Family-centered program.
2. Family preservation program.

"Other adult caretaker" for purposes of the family foster care program means any adult other than a foster parent living in the foster family home who provides care to the foster child on a routine basis in the absence of the foster parent.

"Overpayment" means any payment or portion of a payment made to a provider which is incorrect according to the laws and rules applicable to rehabilitative treatment and supportive services which results in a payment greater than that to which the provider is entitled.

"Physician" means an individual who is a doctor of medicine or osteopathy and is licensed to practice in the state of Iowa pursuant to Iowa Code chapter 148.

"Prime programming time" means any period of the day in a group care program when special attention, supervision, or treatment is necessary; for example, upon awakening in the morning until departure for school, during meals, after school, 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 rehabilitative and supportive services.

"Provider" means any natural person, company, firm, association, or other legal entity seeking certification pursuant to rule 441—185.10(234) or under contract with the department pursuant to this chapter or 441—Chapter 152.

"Psychologist" for the purposes of this chapter means a person who is licensed to practice psychology in the state of Iowa pursuant to Iowa Code chapter 154B.

"Psychosocial evaluation" means services to evaluate the basic strengths of the child and family; assess the emotional needs, health and safety of the child and family; identify the goals and treatment services needed to obtain these goals and expected outcomes; identify the resources available to promote and support these goals; and identify the general functioning of the child.

"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 the review organization and who is responsible for carrying out the follow-up activities after the service necessity determination and service authorization process is completed.

"Rehabilitative treatment need" means a medical-behavioral health need of a child with a deficit in function or skill that the child lost or never gained as a result of interference in the normal maturational and learning process due to the child or parental dysfunction. The child must have the capability to benefit from the rehabilitative treatment services.

"Rehabilitative treatment services" involves services designed to restore a function or skill that an individual lost or never gained as a result of interference in the normal maturational and learning process due to individual or parental dysfunction. The individual must have the capability to learn the function or skill. Rehabilitative treatment services are designed to address the specific medical-behavioral health needs of the child. Rehabilitative treatment services are designed to address the treatment needs of a child in one of the following programs:

1. Family-centered.
2. Family preservation.
3. Family foster care.
4. Group care.

"Related human service field" means psychology; mental health counseling; family therapy; child and family services; family services; child, parent, and community services; human services; sociology; family studies; human relations; criminal justice; chemical dependency counselor program; or nursing. It also includes other degrees in which the student receives educational preparation in the following: therapy and counseling techniques; the development of interview, relationship building, and assessment skills; group dynamics; crisis intervention techniques; social change theories; social system theories; abnormal psychology; sociological concepts and theories as they relate to individuals, families, and groups; and sociological and psychological methods to analyze social problems. Special education, law enforcement administration, political science, and elementary education are not considered related human service fields.

"Restorative living skills development" means rehabilitative services to restore the child's and family's ability to function independently in the community on a daily basis. Skills training and supervision include, but are not limited to: food planning and preparation, maintenance of living environment, time and money management, personal hygiene and self-care.

"Review organization" means the entity designated by the department to make rehabilitative treatment services authorization determination.

"Scope" means the rehabilitative treatment service selected and the service cores or level of care within the program that is selected.

"Service authorization" means the process of service necessity determination and service authorization of scope, amount and duration by the review organization.

"Service code" means the identifier which describes services provided.

"Service core" means a set of treatment services within a rehabilitative treatment service delivered to a child and family that addresses the needs of the child and family.

"Site" means a location from which services are delivered, staff report, and records are kept. In the family foster care and group care programs each separately licensed location would be a site.

"Sleeping time" means any period of the day in a group care program in which children are normally sleeping.

"Social skills development" means services to restore a child's and family's communication and socialization skills. Interventions would restore a child's and family's ability to solve problems, resolve conflicts, develop appropriate relationships with others and develop techniques for controlling behavior.

"Supportive services" means family-centered supportive services as defined in 441—Chapter 182, supervision and home studies in family foster care provided pursuant to 441—Chapter 156, and group care maintenance pursuant to 441—Chapter 156.

"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 provision of rehabilitative treatment and supportive services.

"Therapy and counseling services" means services to halt, control or reverse undue stress and severe social, emotional or behavioral problems that threaten, or have negatively affected the child's and the child's family's stability. Activities under this service can include counseling and therapy to children, groups and families, including interventions to ameliorate difficult behaviors.

"Treatment plan" means a written, goal-oriented plan of service developed for a child and family by the provider.

"Treatment services" means the individual service types included in the services cores or levels of care. These include:

1. Restorative living skills development.
2. Family skill development.
3. Social skills development.
4. Therapy and counseling services.
5. Psychosocial evaluation.
6. Behavioral management for children in therapeutic foster care.

"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 rehabilitative treatment and supportive services program and to which the provider is entitled.

"Universe" means all items (claims), submitted by a specific provider for payment during a specific time 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.

441—185.2(234) Eligibility. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.3(234) Referral for service authorization. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.4(234) Review organization. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.5(234) Adverse authorization actions by the review organization. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.6(234) Appeals. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.7(234) Transition to the review organization. Rescinded 4/11/07, effective 7/1/07.

441—185.8(234) Appeals. Rescinded IAB 7/1/98, effective 8/15/98.

441—185.9(234) Interim provider certification standards. Rescinded IAB 11/5/97, effective 1/1/98.

441—185.10(234) Provider certification standards. Certification is the process by which the department shall ensure that providers meet the requirements for provision of rehabilitative treatment services.

Each provider of rehabilitative treatment services shall meet the following criteria for certification:

185.10(1) *Staff qualifications.* The provider of the following services shall document the credentials and experience of the individuals providing services under the rehabilitative treatment program.

a. Therapy and counseling services, psychosocial evaluation and behavioral management services for children in therapeutic foster care shall be provided by staff who meet one of the following minimum education and experience or professional licensing criteria:

(1) Graduation from an accredited four-year college, institute 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. These individuals shall have been employed prior to September 1, 1993, by an agency with interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or be an individual with interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide therapy and counseling, psychosocial evaluation, or behavioral management services for children in therapeutic foster care if they change place of employment.

(2) 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.

(3) Graduation from an accredited four-year college, institute 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.

(4) A master's degree in social work or related human service field from an accredited college, institute or university.

(5) Graduate education in the social work or related human services field from an accredited college, institute or university may be substituted for up to a maximum of 30 semester hours for one year of the required experience.

(6) Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work or related human service field. These individuals shall have had continuous employment in the same agency since August 31, 1993, and the agency shall have received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or be an individual who received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide therapy and counseling, psychosocial evaluation, or behavioral management services for children in therapeutic foster care if they change place of employment before they have two years of experience.

(7) Licensed in Iowa as an independent social worker, master social worker, psychologist, psychiatric mental health nurse practitioner, marital and family therapist or mental health counselor.

b. Skill development services shall be provided by staff who meet one of the following minimum education and experience or professional licensing criteria:

(1) Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work, or related human service field.

(2) Graduation from an accredited four-year college, institute or university and the equivalent of one year of full-time experience in social work or in the delivery of human services in a public or private agency. Individuals with this level of education who provided skill development services prior to September 1, 1993, can provide skill development services without the one year of experience, if they have maintained continuous employment since August 31, 1993, with an agency that received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or if they had a family-centered contract with the department prior to September 1, 1993, and were granted interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide skill development if they change place of employment before they have one year of experience.

(3) Graduate education in social work, or a related human service field from an accredited college, institute or university may be substituted for up to a maximum of 30 semester hours for one year of required experience.

(4) A high school diploma or GED and the equivalent of one year of full-time experience in social work, or experience in the delivery of human services in a public or private agency. Individuals with this level of education

who provided skill development services prior to September 1, 1993, can provide skill development services without the one year of experience if they have maintained continuous employment since August 31, 1993, with an agency that received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or had a family-centered contract with the department prior to September 1, 1993, and received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide skill development if they change place of employment before they have one year of experience.

(5) Graduation from an accredited community college with a two-year associate degree in a related human service field or an associate of science career option degree, or graduation from a certified two-year nursing program.

(6) Sixty college credit hours toward a degree in social work or a related human service field from an accredited four-year college, institute or university may be substituted for the one year of required experience when at least 12 of the 60 hours are in the field of social work or a related human service field.

(7) Licensed in Iowa as an independent social worker, master social worker, bachelor social worker, psychologist, psychiatric mental health nurse practitioner, marital and family therapist or mental health counselor.

185.10(2) *Staffing requirements.* The agency or individual shall certify that they meet the staffing ratios set forth in this chapter. The agency or individual shall maintain records to demonstrate that qualified staff responsible for direct provision or supervision of rehabilitative treatment services are present in sufficient number to meet the requirements.

185.10(3) *Supervision requirements.* Provider staff who provide skill development services and who do not meet the qualifications for provision of therapy and counseling pursuant to 185.10(1)*"a"* shall receive supervision by an employee or consultant with those qualifications. Supervision shall occur on a face-to-face basis, and may be conducted on an individual or group basis. The provider shall document the date of supervision meetings, who was present, and the general focus of discussion. Supervision requirements may be waived for staff who are absent due to vacation or sick leave.

a. For individuals who meet the qualifications in 185.10(1)*"b"*(4) and who work full-time, supervision shall occur no less than once per week. For individuals who meet the qualifications in 185.10(1)*"b"*(4) and who work part-time, supervision shall occur no less than once every two weeks.

b. For individuals who meet the qualifications in 185.10(1)*"b"*(1), 185.10(1)*"b"*(2), 185.10(1)*"b"*(3), 185.10(1)*"b"*(5), or 185.10(1)*"b"*(6) and who work full-time, supervision shall occur at least two times per month. For individuals who meet the qualifications in 185.10(1)*"b"*(1), 185.10(1)*"b"*(2), 185.10(1)*"b"*(3), 185.10(1)*"b"*(5), or 185.10(1)*"b"*(6) and who work part-time, supervision shall occur no less than once a month.

185.10(4) *Treatment plan development.* The provider shall develop a treatment plan for each individual and family receiving treatment services except for the psychosocial evaluation services core. Treatment plans shall meet the following conditions:

a. The treatment plan shall be developed in collaboration with the referral worker, child, family, and, if applicable, the foster parents unless the treatment 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 treatment plan. The provider shall provide a copy of the treatment plan to the family and the referral worker, unless otherwise ordered by the court.

b. Initial treatment plans shall be developed after services have been authorized and within 30 calendar days of initiating services, except in the case of the family preservation program the treatment plan shall be developed within 10 calendar days of initiating services.

c. The treatment plan shall identify the following:

(1) Strengths and needs of the child and family.

(2) Goals, which are statements of outcomes to be achieved to meet the medical-behavioral health care needs of the child identified on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

(3) Objectives, which are specific, measurable, and time-limited statements of indicators, levels of competence or accomplishments of the child 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. When providing restorative living and social skill development in a group care setting, designation may be by job title.

(6) Date of service initiation and date of treatment plan development.

185.10(5) *Treatment plan review and revision.* Individuals qualified to provide therapy and counseling services pursuant to paragraph 185.10(1)*"a"* shall review the services identified in the treatment plan to ensure that the services are necessary, appropriate, and consistent with the identified medical-behavioral health care needs of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

a. All treatment plans shall be reviewed as follows:

(1) Ninety calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

(2) When any changes are made by the review organization to the identified medical-behavioral health care need of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

(3) Five working days after a skill development qualified staff has developed an initial or revised treatment plan for skill development services.

b. All treatment plans shall be revised when any of the following occur:

(1) Treatment goals or objectives have been achieved.

(2) Progress is not being made.

(3) Changes have occurred in the identified medical-behavioral treatment needs of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

(4) The treatment plan is not consistent with the identified medical-behavioral treatment needs of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

c. The treatment plan shall be signed and dated by qualified staff after each review and revision. The treatment plan shall be revised in collaboration with the child, family, referral worker and, if applicable, the foster parents. The revision of the treatment plan must reflect the services authorized and the identified medical-behavioral health care needs of the child. The revised treatment plan must meet the requirements for a treatment plan in paragraph 185.10(4)*"c."* The provider shall provide a copy of all the revised treatment plans to the family and referral worker, unless otherwise ordered by the court.

185.10(6) *Treatment records.* The agency or individual shall maintain confidential individual records for each individual or family receiving treatment services. The record shall include the following:

a. Case permanency plan as supplied by the referral worker.

b. Documentation of billed services. Documentation shall include: the date and amount of time services were delivered except when delivering restorative living and social skill development services in a group care setting only the date and shift hours shall be identified, who rendered the services, the setting in which the services were rendered, the specific services rendered and the relationship of the services to the services described in the treatment plan, and updates describing the client's progress. For the family preservation program this documentation shall be provided every ten days on Form 470-2413, Family Preservation Service Report.

c. All initial and revised treatment plans developed by the agency.

d. Correspondence with the referral worker regarding change in the case permanency plan or treatment plan or requests for authorization for additional services and any relevant evaluation activities including procedures and tests completed.

e. Discharge summary which identifies the reason for discharge, date of discharge, the recommended action or referrals upon discharge, treatment progress, and outcomes.

f. Progress reports 90 calendar days after initiating services and every 90 calendar days thereafter which summarize progress and problems in achieving the goals and objectives of the treatment plan. The progress report shall be written in conjunction with the treatment plan review and shall be completed no more than 15 calendar days before the report is due or 15 calendar days after the report is due. This report may serve as either a discharge summary or a recommendation for continued rehabilitative treatment service. If the report serves as a discharge summary, the report shall meet the requirements for a discharge summary. The provider shall provide a copy of all progress reports to the family and referral worker, unless otherwise ordered by the court.

g. For psychosocial evaluation services, evaluation reports.

h. Additional reports if requested by the referral worker.

i. Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

185.10(7) *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 treatment staff. The 24 hours of training shall include: training on children and families' mental health service topics, and two hours of training related to the identification and reporting of child abuse for all

employed or contracted treatment 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 and contracted treatment staff. The 12 hours of training shall include: training on children and families' mental health service 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.

185.10(8) *Other conditions of certification.* To receive full certification providers shall meet the following conditions if applicable:

a. Rescinded IAB 4/11/07, effective 7/1/07.

b. Rescinded IAB 4/11/07, effective 7/1/07.

c. Rescinded IAB 4/11/07, effective 7/1/07.

d. Providers of family-centered psychosocial evaluation shall prepare within 14 calendar days following termination of services evaluation reports which summarize the results and recommendations of the psychosocial evaluation services provided to a child and family. The provider shall provide a copy of this evaluation report to the family and referral worker, unless otherwise ordered by the court. The evaluation report shall contain the following information:

(1) Sources of information and methods of assessing and observing the child and family used to complete the evaluation.

(2) Answers to any specific questions from the referral worker.

(3) Child and family safety and risk factors.

(4) Child and family strengths, including how these strengths may be used in further service delivery.

(5) Recommendations for further services including suggested goals, objectives, and methods of service delivery.

e. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.11(234) Provider certification. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.12(234) Sanctions against providers of rehabilitative treatment and supportive services. Failure to meet the requirements relevant to provider certification, contracting, cost reporting, billing and payment, and documentation may subject providers to sanctions.

185.12(1) *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 compensations than that to which the provider is legally entitled.

c. Submitting or causing to be submitted false information for the purpose of meeting service authorization requirements.

d. 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.

e. Failing to provide and maintain the quality of the services to children and families within established standards.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations, or continuing that conduct following notification that it should cease.

g. Overutilizing rehabilitative treatment services by inducing, furnishing or otherwise causing the child or family to receive services or merchandise not authorized.

h. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

i. Submitting a false or fraudulent application for provider status for rehabilitative treatment services.

j. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professionals subject to this chapter.

k. Being convicted of a criminal offense relating to negligent practice resulting in death or injury to clients.

l. Failing to meet standards required by state or federal law for certification, for example, licensure.

m. Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

n. Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

o. Being suspended or terminated from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicaid.

p. Committing fraudulent billing practices.

q. Committing negligent practice resulting in death or injury to the provider's clients.

r. Failing to repay or make arrangement for the repayment of identified overpayments or other erroneous payments.

185.12(2) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 185.12(1).

a. A term of probation for provision of rehabilitative treatment services.

b. Termination from participation in the provision of rehabilitative treatment services.

c. Suspension from provision of rehabilitative treatment services.

d. Suspension or withholding of payments to provider.

e. One hundred percent review of the provider's claims prior to payment.

f. Referral to the state licensing board for investigation.

g. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

h. Suspension of rehabilitative treatment services certification.

i. Termination of rehabilitative treatment services certification.

185.12(3) *Imposition and extent of sanction.* The decision on the sanction to be imposed shall be the department's. 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. Provider 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.

185.12(4) *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 factors 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 provision of rehabilitative treatment services shall preclude the provider from submitting claims for payment whether personally or through claims submitted by a clinic, group, corporation, or other association to the department for any services provided after suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payments to the department for any services or supplies provided by a person within the association who has been suspended or terminated from provision of rehabilitative treatment services except for those services provided prior to the suspension or termination.

d. When there are grounds for sanction pursuant to subrule 185.12(1) against 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.

185.12(5) *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.

185.12(6) *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. 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.

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.

185.12(7) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation pursuant to 185.12(6) 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. When the department intends to withhold or suspend payments, it shall notify the provider in writing.

441—185.13(234) Provider audits.

185.13(1) *Provider monitoring.* The department shall have the authority to conduct a scheduled or an unannounced site visit to evaluate the adequacy of documentation in compliance with the policies and procedures for rehabilitative treatment and supportive services. The provider shall maintain the following documentation for each program.

a. List of all staff and supervisors providing services and their qualifications.

b. Number of staff hired and terminated in the year to date.

c. to *g.* Rescinded IAB 1/4/95, effective 2/1/95.

185.13(2) *Audit of clinical and fiscal records by the department.*

a. Authorized representatives of the department shall have the right, upon proper identification, and using generally accepted auditing procedures, to review the clinical and fiscal records of the provider to determine whether:

(1) The department has accurately paid claims for goods or services.

(2) The provider has furnished the services.

(3) The provider has retained clinical and fiscal records which substantiate claims submitted for payment during the audit period as described at 441—Chapters 156 and 182, subrules 185.10(6) and 185.102(3), and rule 441—79.3(249A).

b. Records generated and maintained by the department or its fiscal agent may be used by auditors and in all proceedings of the department.

c. Any service provider may be audited at any time at the discretion of the department.

d. The department shall select the appropriate method of conducting an audit 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. Audit procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing recipients of services and employees of providers.

e. The department's procedures for auditing rehabilitative treatment services providers 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. Findings of the sample will be extrapolated to the universe for the audit period.

(1) The audit findings generated through the audit procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

(2) When the department's audit findings have been generated through the use of 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 of the universe of provider records used by the department in the drawing of the department's sample. This audit 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 were in compliance with program regulations.

4. Be submitted to the department with all supporting documentation.

(3) The total of the payments determined to be in error in the audit sample shall be divided by the total payments in the reviewed audit sample to calculate the percentage of dollars paid in error. This sample error payment rate shall then be multiplied by the total dollars in the audit universe from which the audit sample was selected to determine the extrapolated overpayment.

f. Actions based on audit findings.

(1) The department shall report the results of an audit of provider records to concerned parties consistent with the provisions of 441—Chapter 9.

(2) When an overpayment is found, the department may proceed with one or more of the following:

1. Request repayment in writing.
2. Impose sanctions provided for in rule 441—185.12(234).
3. Investigate and refer to an agency empowered to prosecute.

g. Appeal by provider. Providers may appeal decisions of the department according to rules in 441—Chapter 7.

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

441—185.14 to **185.20** Reserved.

DIVISION II
FAMILY-CENTERED PROGRAM
Rescinded IAB 4/11/07, effective 7/1/07

441—185.21 to **185.40** Reserved.

DIVISION III
FAMILY PRESERVATION PROGRAM
Rescinded IAB 4/11/07, effective 7/1/07

441—185.41 to **185.60** Reserved.

DIVISION IV
FAMILY FOSTER CARE TREATMENT SERVICES
Rescinded IAB 11/8/06, effective 11/1/06

441—185.61 to **185.80** Reserved.

DIVISION V
GROUP TREATMENT
Rescinded IAB 4/11/07, effective 7/1/07

441—185.81 to **185.100** Reserved.

DIVISION VI
ESTABLISHMENT OF RATES

441—185.101(234) Definitions. These definitions shall apply to this division of 441—Chapter 185 only.

"Accrual basis accounting" means the generally accepted accounting principle which requires that revenue be recognized as earned and expenses be recognized as incurred.

"Across-the-board increase" means a uniform percentage or fixed dollar increase of those rates established by nonexceptional means.

"Benefits" means compensation in the form of access to services made available by the employer.

"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.

"Control" means that relationship existing where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

"Co-therapy" means the use of two qualified therapists for group therapy and counseling services.

"Department" means the Iowa department of human services.

"Group service" refers to a service in which two or more nonrelated persons participate. For purposes of this definition, one or more persons from a family represent one person.

"Host area" means the department service area that is responsible for administering the provider's contract with the department to provide rehabilitative treatment and supportive services.

"Indirect cost" means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

"Individual provider" means a person under contract pursuant to 441—Chapter 152 who delivers rehabilitative treatment and supportive services independent of a partnership, corporation, agency, governmental unit or any other legal entity.

"Individual service" refers to a service in which one person participates in a service. For purposes of this definition, one or more persons from a family represent one person.

"Interest" means 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.

"Multiple program provider" means a provider which delivers more than one program under a contract with the department pursuant to 441—Chapter 152.

"Necessary costs" means costs essential to the provision of rehabilitative treatment and supportive services and to the achievement of service requirements and outcomes up to the extent required by standards established for the services.

"Negotiated rate" means the rate of payment established by the department as a result of negotiations between the provider and the department based upon the allowable reasonable and necessary costs of service provision.

"Occupancy costs" means expenses related to the acquisition, maintenance, and financing of a property, or rental of property necessary for service.

"Program" means the specific support service, core, level of care, or in the case of group care, maintenance.

"Provider" means any natural person, company, firm, association, or other legal entity seeking certification pursuant to rule 441—185.9(234) or 441—185.10(234) or under contract with the department pursuant to 441—Chapter 152.

"Rate resolution process" means a time-limited structured process involving an independent mediator to facilitate discussions with the goal of producing mutual agreement when the department and the provider have been unable to reach agreement on a rate during the rate negotiation process.

"Reasonable costs" means the level of costs which will be recognized for reimbursement purposes.

"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.

"Similar or same services" means services which have the same first three digits in their service code.

441—185.102(234) Financial and statistical report. The Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, shall be the basis for establishing the rates to be paid to all providers, both in-state and out-of-state. The Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, shall be completed by providers according to the following requirements:

185.102(1) *Accounting procedures.* Financial information shall be based on the agency's financial records. Providers are required to comply with the following specific requirements:

a. Providers shall report on an accrual basis of accounting. 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.

b. Revenues shall be reported as recorded in the general ledger and adjusted for accruals. Allowance and expense recoveries shall be reflected as revenues.

c. 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 provider. No private moneys contributed to the provider 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.

d. Depreciation expense reported on the Capital Asset Use Allowance Schedule shall be computed according to 42 CFR 413.130 as amended to September 23, 1992, and the method (straight line depreciation) used as described at 42 CFR 413.134(a)(3)(i) as amended to September 23, 1992. For assets acquired on or after November 1, 1993, useful lives may be based on the 1988 American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets." The 1981 edition of the AHA Guide shall continue to be used to compute useful lives of assets acquired prior to November 1993.

e. Assets shall be depreciated when the asset has a useful life of more than one year and a cost in excess of $500.

185.102(2) *Cost allocation.* The cost allocation schedule shall be prepared in accordance with recognized methods and procedures, including the following:

a. 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 has supervised more than one program.

b. Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program.

c. A multiple program provider shall establish a method of cost allocation acceptable to the department. All expenses which relate jointly to two or more programs shall be allocated to programs by utilizing a documented cost allocation method consistently applied. The allocation method shall equitably distribute indirect program costs to reflect the benefit of the cost incurred to all applicable programs.

d. Occupancy expenses shall be allocated on a space utilization formula.

e. Family-centered, family foster care or group treatment optional therapy and counseling services may have a rate determined in common.

Family-centered, family foster care or group treatment optional skill development services may have a rate determined in common.

All services with rates determined in common shall have their maximum occupancy costs established pursuant to subrule 185.105(5) for family-centered, family preservation, or family foster care.

All services with rates determined in common shall have their maximum administrative costs established pursuant to subrule 185.105(7) for family-centered, family preservation, or family foster care.

185.102(3) *Records retention.* All revenue and expenses reported on Form 470-3049 shall be supported by a provider's general ledger and documentation on file in the provider's office. Failure to maintain records adequate to support the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, may result in sanction or termination of the contract or other sanctions pursuant to rule 441—185.12(234). These records include, but are not limited to:

a. Payroll information.

b. Capital asset schedules.

c. All canceled checks, deposit slips, invoices (paid and unpaid).

d. Audit reports (if any).

e. Board of directors' minutes (if applicable).

f. Loan agreements and other contracts.

g. Reviewable, legible census reports and documentation of units of service provided to department clients which identify the individual client shall be available on a daily basis and summarized on a monthly report. For nondepartment clients, sufficient documentation of utilization shall be maintained and made available to establish a complete unit of service count. The documentation prepared shall be retained by the provider for use at the time the financial and statistical report is prepared and for review by the department's fiscal consultant.

h. Financial records must be retained for five years from the date of report submission as specified in 441—subrule 152.2(14).

185.102(4) *Independent audits.* When a provider has an independent audit conducted, the provider shall submit a copy of the independent audit report to the department within 30 days of receipt. A firm not related to the provider shall conduct the independent audit. The bureau of purchased services shall receive and maintain the report and provide a copy of the report to the bureau's fiscal consultant.

a. The department requires independent audits on an annual basis when a provider receives from the department $500,000 or more from funds paid under contracts for rehabilitative treatment and supportive services and purchase of services for services provided in any state fiscal year.

(1) The legal entity that has contracted with the department must be the subject of this independent audit.

1. When the legal entity that has contracted with the department is a subsidiary of another legal entity and a separate independent audit of the contracting entity is not performed because a consolidated or combined audit of the larger entity is required by American Institute of Certified Public Accountants (AICPA) standards, the department will accept the consolidated or combined audit if supplemental schedules that separately identify the financial statements of the contracting legal entity are provided.

2. When contract services are provided by a subsidiary entity of the contracting entity and a consolidated or combined audit is performed, the department may require supplemental schedules to separately identify the financial statements of the subsidiary entity and the contracting entity. If a consolidated or combined audit is not performed, the department may require that the subsidiary entity also be the subject of an independent audit.

(2) Required audits shall be completed within six months of the end of a provider's established fiscal year end for the provider's established fiscal year that ends during the state fiscal year in question. The bureau of purchased services may approve an extension of this time period upon written request from the provider.

(3) Not-for-profit providers shall ensure that the audit of their financial statements follows one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants in the most recent version of the AICPA Audit and Accounting Guide for Not-for-Profit Organizations.

(4) Other types of providers shall ensure that the audit of their financial statements follows the formats prescribed by the AICPA for their specific industry.

b. Providers receiving less than $500,000 from funds paid under contracts for rehabilitative treatment and supportive services and purchase of services for services provided in any state fiscal year annually are not required to have an independent audit. They shall submit a copy, as set forth in this rule, of any independent audit report they receive as a result of conducting an independent audit.

441—185.103(234) Submission of reports.

185.103(1) *New providers or current providers adding a new program.* New providers or current providers adding a program not currently under a contract developed pursuant to 441—Chapter 152 shall:

a. Submit a projected budget using the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, 60 days prior to the desired contract effective date. The projected budget shall not duplicate direct or indirect costs paid by established program rates. New costs to be incurred as a result of the new program shall be included in the initial program budget.

b. Submit Form 470-3049 for the first six months of service (first actual report). The report shall be submitted within two months of the close of the reporting period. The first actual report shall not duplicate direct or indirect costs paid by established program rates. New costs incurred in the delivery of the new program shall be included in the first actual report. When the first actual report is contained in the year-end fiscal report, direct and indirect costs shall be allocated across all programs according to existing practice rules for cost allocations pursuant to 185.102(2)*"c"* and these costs shall be prorated according to the length of time each program was in operation during the fiscal year.

185.103(2) *Ongoing providers.* All providers shall submit Form 470-3049 no later than three months after the close of the provider's established fiscal year. The year-end fiscal report shall allocate direct and indirect costs across all programs according to existing practice rules for cost allocation pursuant to 185.102(2)*"c"* and shall prorate these costs according to the length of time each program was in operation during the fiscal year.

185.103(3) *Review by project manager.* The project manager shall review Form 470-3049, and transmit it to the bureau of purchased services within two weeks of receipt.

185.103(4) *Untimely submission of financial report.*

a. Failure by providers to submit the report in time without written approval from the chief, bureau of purchased services or designee may be cause to reduce payment to 75 percent of the current rate.

b. Failure to submit a complete and correctly prepared report within six months of the date the report is due shall be cause for terminating the contract.

185.103(5) *Periodic review and audit.* Providers may be subject to periodic financial reviews and audits. Exceptions to costs identified by the department or its fiscal consultant shall be communicated to the provider in writing.

185.103(6) *Noncompliance.* When adjustments to prior financial and statistical reports indicate noncompliance with reporting instructions, the department may require the provider to submit an audited financial and statistical report and the certified public accountant's or public accountant's opinion.

185.103(7) *Reimbursement of individual providers.* A provider who is an individual shall have the option of obtaining a rate by completing the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, or accepting a rate established by adding the following. Costs not specified below, including transportation costs, shall not be allowed.

1. The maximum salary established for skill development or therapy and counseling pursuant to 185.105(1)*"c"* or *"f,"* as applicable to the service provider.
2. The maximum level established for benefits pursuant to subrule 185.105(2).
3. The maximum occupancy established pursuant to subrule 185.105(5) for family-centered, family preservation, or treatment in foster family care.
4. The maximum administrative costs allowed pursuant to subrule 185.105(7) for family-centered, family preservation, or treatment services in foster family care.

Rates shall be established upon initial submission and recalculated annually on the anniversary of the effective date of the contract.

441—185.104(234) Expenses not allowed. The following expenses are not reimbursable to rehabilitative treatment providers and shall be excluded from rehabilitative treatment service costs.

1. Fees paid to directors and nonworking officers' salaries.
2. Bad debts.
3. Entertainment expenses.
4. Memberships in recreational clubs paid for by a provider (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the provider's employees, owners, executives, board members, and related parties.
5. Legal assistance on behalf of clients.
6. Costs for health care services other than the rehabilitative treatment services.
7. Food and lodging expenses for personnel incurred in the county of the personnel's residence or office of employment. Exceptions will be allowed for food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, or guardians when documentation to support the expense, those benefiting from the expense and the specific therapeutic necessity is available for audit purposes.
8. Business conferences, conventions, and meetings of a provider not required for licensure, contracting for or certification of rehabilitative treatment or supportive services. Expenses associated with meetings called by the department will be reimbursable.
9. Awards and grants to recognize board members, employees, and community citizens for achievement. Awards and grants to clients as part of rehabilitative treatment or supportive services are reimbursable.
10. Survey costs other than those specifically required for certification of rehabilitative treatment and supportive services.
11. Federal and state income taxes.
12. Contributions to a contingency reserve or any similar provision for unseen events are unallowable. Contributions to a reserve for a self-insurance program are allowable to the extent that the type of coverage, extent of coverage, and the rates and premiums would have been allowed had insurance been purchased to cover the risks.
13. Outlays of cash with no prospective benefit to the facility or program, such as deposits, down payments and retainers.
14. Only assets acquired at a cost to a provider shall be depreciated. The depreciation level is limited to the amount expended to acquire the asset and place the asset in service.
15. Cost of fines and penalties resulting from failure to comply with federal, state and local laws or court rulings.
16. Costs of organized fund-raising in excess of revenues and donations received from fund-raising.
17. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments and any investment losses.
18. Costs of prohibited activities for Internal Revenue Code Section 501(c)(3) organizations.
19. Organizational costs such as incorporation, fees to accountants, lawyers, brokers, for example, in connection with establishment or reorganization.
20. Advertising for client solicitation and all public relations expense are not reimbursable.
21. Imputed rental costs or other estimates of occupancy costs.

22. Costs for payments to foster parents or on behalf of a foster child, the 12 hours of preservice training, or the six hours of in-service training required for foster parent licensure and foster family insurance. The cost of foster family recruitment and foster family home studies are allowable only when the service for which the rate is being determined is the foster family home study within the conditions set forth at 441—156.7(4).

23. Costs resulting from staffing levels in excess of the minimum required by licensing or certification, whichever is higher and costs specifically limited or not allowed in the rules for a particular service. Group treatment prime programming time costs or costs resulting from staffing levels in excess of the minimum level required by licensing or certification may be allowed only to the extent that it has been determined by the certification process that the hours of prime time and a higher staff-to-client ratio are required to appropriately meet the needs of the children being served during prime programming time, nonprime programming time and sleeping time.

24. All interest expenses. This rule applies to rates established on or after March 1, 1994.

441—185.105(234) Costs subject to limits. The department intends to reimburse providers for their reasonable and necessary costs of providing rehabilitative treatment and supportive services. For purposes of establishing payment rates for rehabilitative treatment and supportive services, the following necessary costs and categories of cost are limited to the stated reasonable levels:

185.105(1) *Salaries.* Reimbursable salaries per full-time equivalent administrative staff may not exceed the salary range established by the Iowa department of personnel for the comparable positions during the fiscal year. Reimbursable salaries for direct care and clerical staff may not exceed the percents specified in 185.105(1)*"b"* to 185.105(1)*"g"* of salary ranges established by the Iowa department of personnel for the comparable positions. The comparable positions are listed below:

a. Administrative staff described in account 2110 - Step 1, Human Service Area Administrator III.

b. Direct care supervisors. Effective November 1, 1993, the average salary shall not exceed 85 percent of the midpoint for a Social Worker III Supervisor. Effective July 1, 1994, the average salary shall not exceed 87 percent of the midpoint for a Social Worker III Supervisor. Effective July 1, 1995, the average salary shall not exceed 88 percent of the midpoint for a Social Worker III Supervisor. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Social Worker III Supervisor.

c. Professional skill development staff for family-centered, family foster care, family preservation services, and group care optional services. Effective November 1, 1993, the average salary shall not exceed $25,053. Effective July 1, 1995, the average salary shall not exceed 90 percent of the midpoint for a Social Worker II. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Social Worker II.

d. Professional skill development staff in group homes and staff providing family-centered respite care and family-centered supervision services. Effective November 1, 1993, the average salary shall not exceed 70 percent of the midpoint for a Residential Treatment Worker. Effective July 1, 1994, the average salary shall not exceed 77 percent of the midpoint for a Residential Treatment Worker. Effective July 1, 1995, the average salary shall not exceed 84 percent of the midpoint for a Residential Treatment Worker. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Residential Treatment Worker.

e. Direct care staff working during the hours children would normally be asleep. The average salary shall not exceed 90 percent of the salary level established at 185.105(1)*"d."*

f. Therapy and counseling staff, psychosocial evaluation and behavioral management for children in therapeutic foster care staff. Effective November 1, 1993, the average salary shall not exceed 85 percent of the midpoint for a Social Worker III. Effective July 1, 1994, the average salary shall not exceed 87 percent of the midpoint for a Social Worker III. Effective July 1, 1995, the average salary shall not exceed 88 percent of the midpoint for a Social Worker III. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Social Worker III.

g. Clerical and secretarial staff. Effective November 1, 1993, the average salary shall not exceed 80 percent of the midpoint for a Clerk Typist III. Effective July 1, 1994, the average salary shall not exceed 83 percent of the midpoint for a Clerk Typist III. Effective July 1, 1995, the average salary shall not exceed 87 percent of the midpoint for a Clerk Typist III. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Clerk Typist III.

h. Fees paid to subcontractors providing or supervising the provision of rehabilitative or supportive services shall be subject to the applicable limitations described in 185.105(1)*"a"* to *"g"* or the maximum flat rate per full-time equivalent position established by the department by adding the following:

(1) The maximum salary established for therapy and counseling or direct care supervision pursuant to 185.105(1)*"b," "c,"* or *"f,"* as applicable to the provider.

(2) The maximum level established for benefits pursuant to subrule 185.105(2).

(3) The maximum occupancy established pursuant to subrule 185.105(5) for family-centered, family preservation, or treatment in foster family care.

(4) The maximum administrative costs allowed pursuant to subrule 185.105(7).

The costs of subcontractors providing program consultation shall be reported as training costs.

185.105(2) *Employee benefit costs.* Employee benefits costs shall be limited to the percentage of salaries and wages budgeted for benefits by the department for the state fiscal year in which the agency's fiscal year begins. The percentage shall be applied to adjusted salaries. The actual budgeted percentage rate shall be rounded to the nearest one-half percent. The only exception that may be granted to this percentage is when a provider's health care premium increases substantially because the provider's health care group size is small and within the past year employee utilization of health care is the rationale for the increased premium. In order for this exception to be considered by the chief of the bureau of purchased services, the provider shall document that the increase is related to the employee utilization and that bids from three other comparable health care coverage sources have been received and these bids are similar to the provider's current health care rate.

185.105(3) *Food cost.* Food cost per day in group care shall not exceed the weighted average of food costs by child age range published in the U.S. Department of Agriculture, Family Economics Group survey. The published indices for low- and middle-income rural and Midwestern urban families shall be weighted by the percentage of children by age range in group care and shall be updated for inflation using the Consumer Price Index for Food at Home.

185.105(4) *Clothing cost.* Clothing cost per day in group care shall not exceed 65 percent of the weighted average of clothing costs by child age range published in the U.S. Department of Agriculture, Family Economics Group survey. The published indices for low- and middle-income rural and Midwestern urban families shall be weighted by the percentage of children by age range in group care and updated for inflation using the Consumer Price Index - Urban.

185.105(5) *Occupancy costs.* After all other limitations, reimbursable occupancy costs will be limited to the lower of actual provider costs or the applicable limit under *"a"* or *"b"* below:

a. Group care services - 16.7 percent of total group care costs.

b. Family-centered, family foster care and family preservation services - 6.4 percent of the total costs of these services.

185.105(6) *Transportation costs.*

a. All travel mileage by provider employees in personal or provider vehicles other than vans owned or leased by group care providers shall be reimbursed at the average of the state employee and Internal Revenue Service rates per mile. Travel mileage for transportation of group care clients in a van owned or leased by the group care provider shall be reimbursed at the rate for minivans established by the department of management's budget pricing information for vehicle rates. Per diem costs shall be reimbursed according to applicable state employee policies. All transportation and related costs including, but not limited to, depreciation of vehicles, automobile insurance and maintenance, are included in the per mile rate.

b. Reimbursement for air and other commercial travel shall not exceed the lesser of the minimum commercial rate or the rate for mileage in 185.105(6)*"a"* above.

185.105(7) *Administrative costs.* After all other limitations, administrative costs shall be limited to the lower of actual costs or the applicable limit under *"a," "b,"* or *"c"* below:

a. Group care services - 18.9 percent of total group care costs.

b. Family-centered, family foster care and family preservation services - 15.4 percent of the total costs of rehabilitative treatment and supportive services.

c. For rates established for all rehabilitative treatment and supportive services on or after June 1, 1994, administrative costs shall be limited to the lower of the actual costs or 15.4 percent of the total costs of rehabilitative treatment and supportive services.

185.105(8) *Training costs.* Costs for participation in educational conferences and subscriptions for reference publications and program-related materials are limited to 1.4 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report. The index for training costs will be the Annual American Society of Training and Development survey of U.S. employers.

185.105(9) *Annual meeting costs.* Reasonable annual meeting costs which are required by licensure are allowed.

185.105(10) *Moving and recruitment costs.* 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 recruiting qualified individuals for staff positions are allowed for reimbursement purposes.

185.105(11) *Related party costs.* Costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider through control, from ownership, capital investment, directorship or other means shall be included in the allowable cost of the provider at the cost to the related organization. Only costs which are determined to be necessary and reasonable at the provider level are allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

a. Allowable costs shall be all actual direct and indirect costs applying to any program or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

b. 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 the amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 185.102(2)*"a"* to *"c."*

Financial and statistical records shall be maintained by the related party under the provisions in subrule 185.102(3).

c. Tests for relatedness shall be those specified in paragraph *"a"* and 441—subrule 152.2(18). The department or the department's 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 lists of board members.

185.105(12) *Foster parent training costs.* Costs for foster parent preservice and in-service training are limited to the hours required in 185.9(2)*"b"*(2) and 185.10(8)*"b"*(2).

185.105(13) *Volunteer recognition.* The amount of awards and grants to recognize volunteers whose activities relate to direct client rehabilitative treatment or supportive services shall not exceed $3 per volunteer.

441—185.106(234) Establishment of reimbursement rates. Rates shall be established on the basis of net reasonable and necessary cost per unit of service as reported on the financial and statistical report and adjusted by the department's fiscal consultant.

185.106(1) *Calculation of cost per unit.* Costs per unit of service will be calculated as follows:

a. Aggregate, reasonable and necessary costs as defined in subrules 185.105(1) to 185.105(13).

b. Less non fee-for-service revenues, and certain contributions for services provided to certain individuals.

c. Divided by effective utilization described in 185.106(2)*"a."*

d. Multiplied by the inflation factor as described in 185.106(2)*"b,"* as applicable to costs and cost categories which are not limited or subject to a prospective index.

185.106(2) *Adjusting factors.* Cost-based rates shall be established by applying the following adjusting factors.

a. The effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program except for group care, which shall be as follows. The following effective utilization applies to all rates established on or after July 1, 1995, and shall be used to adjust rates established prior to July 1, 1995, for payment of services provided on or after July 1, 1995.

The effective utilization for group care facilities certified to provide community residential treatment and licensed pursuant to 441—Chapter 116 or 481—Chapter 57 or 63 shall be 95 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

EXCEPTION: The effective utilization for the service portion of the per diem rate for group care facilities certified to provide community residential treatment and licensed pursuant to 441—Chapter 116 or 481—Chapter 57 or 63 shall be 85 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

The effective utilization for all other group care facilities certified to provide community residential treatment and group care facilities certified to provide comprehensive residential treatment or enhanced residential treatment

shall be 90 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

EXCEPTION: The effective utilization for the service portion of the per diem rate for all other group care facilities certified to provide community residential treatment and group care facilities certified to provide comprehensive residential treatment or enhanced residential treatment shall be 85 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

The effective utilization for all services provided by group care facilities certified to provide a highly structured juvenile program, including both the service and maintenance portion of the per diem rate, shall be 90 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

However, subsequent to the report submitted pursuant to 185.103(1)*"b,"* when the provider has failed to achieve a utilization rate of 70 percent during a cost report period, the subsequent rate shall be calculated on the basis of 100 percent of licensed or staffed capacity, whichever is less. This penalty shall be applied to cost reports due on or after December 1, 1994.

b. The applicable inflation factor is the percentage which shall be applied to costs for which prospective indices or other limits have not been established. The inflation factor is intended to overcome the time lag between 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.

(1) The inflation factor shall not be applied to prospective, budgeted costs or when the rate is established based on the report of costs incurred for less than 12 months.

(2) In no event shall the inflation factor cause the occupancy or administrative caps to be exceeded.

c. Rates established at reasonable and necessary cost per unit of service, net of related revenue, shall be subject to 185.106(4).

d. When a ceiling has been authorized by the legislature, the reimbursement rate shall be established by determining on a per unit basis the necessary and reasonable cost plus the current inflation factor subject to the maximum allowable cost ceiling.

e. The indices cited in subrules 185.105(1) to 185.105(4), 185.105(6), and 185.105(8) shall be reviewed and adjusted at the beginning of the state fiscal year and shall be applied to the first actual or the annual cost report due on or after that date. Adjustments shall be based on the most current data available on July 1.

185.106(3) *Rate limits.* Providers will be subject to the following rate limits:

a. Group care floor. For fiscal year 1994, combined service and maintenance components of the reimbursement rate paid to a group care provider shall not be below the rate in effect for that provider on October 31, 1993, or $76.61 per day when a 360-day year is used, whichever is less. The floor shall be $75.56 per day or the rate in effect for that provider on October 31, 1993, when a 365-day year is used.

b. Rates for new providers and for providers adding a new program to an existing contract under 441—Chapter 152. Payment rates for new providers and for providers adding a new program to an existing contract under 441—Chapter 152 shall be established according to the methodology described at 185.106(1)*"a"* to *"d,"* not to exceed the lower of:

(1) Budgeted cost per unit of service as computed under 185.106(1)*"a"* to *"d."*

(2) The seventy-fifth percentile of rates for similar programs as computed at the beginning of the calendar year, beginning January 1, 1995. Rates established pursuant to projected budgets shall not be included in the percentile ranking.

c. Interruptions in a program will not affect the rate. If a provider assumes the delivery of program from another provider, the rate shall remain the same as for the former provider. If a provider ceases to contract for and provide a service or program and later decides to again contract for and provide that program or service and has a contract for that service in effect within two years, the rate shall remain the same as previously paid unless this rate would be in excess of a ceiling authorized by the legislature. However, while those providers who resume contracting for and providing a service within two years will not submit a projected budget to reactivate their rate, they will be required to submit a first actual cost report in accordance with 185.103(1)*"b."* Providers who resume contracting for and providing a service with an interruption of more than two fiscal years shall submit a projected budget in accordance with 185.103(1)*"a."*

d. Rates for public agencies shall not knowingly be established in excess of their actual costs. Public agencies whose rates do exceed their actual costs are required to notify the department within one month of becoming aware of the situation. Once the department or a public provider becomes aware of a situation that will cause a public provider to receive reimbursement in excess of their actual costs, the provider shall request

or the department shall cause the provider's reimbursement rates to be lowered so as to avoid the necessity of a recoupment situation. Recoupment of overpayments, if necessary, will be handled in accordance with 185.122(1).

185.106(4) *Unit of service and unit rates.* For family-centered services, all members of a family shall collectively be considered one recipient of any unit of family-centered service. Service to the family or one or more of its members shall be considered one unit of service. For family foster care and group care, the child shall be considered the recipient of any unit of service.

a. The unit of service for family-centered and family foster care services shall be one-half hour of service provided on a face-to-face basis and directed toward the child. Monthly cumulative units shall be rounded up or down to the nearest whole unit.

b. The unit of service for family preservation shall be the family.

c. The unit of service for the required services provided in group care shall be one day based on a 365-day year. Rates in effect prior to July 1, 1995, shall be adjusted by multiplying them by 360 and dividing the result by 365 to establish the new rates effective July 1, 1995. Rates established on or after July 1, 1995, based on statistical information using a 360-day year shall be similarly adjusted. The unit of service for additional and optional services shall be one-half hour of service provided on a face-to-face basis and directed toward the child.

d. When co-therapy is provided, the provider shall bill at the rate for the unit of service for one therapist except as provided for as follows:

(1) When co-therapy is provided, the payment rates shall be determined by dividing the reasonable and necessary cost for the service by the average number of unrelated persons in attendance in the group.

(2) The co-therapy rate may be billed when the group consists of two or more families and four or more children. The rate for co-therapy shall be no more than 150 percent of the rate for group therapy and counseling services using one therapist. When the provider does not have a rate established for group therapy and counseling services using one therapist, 150 percent of the median rate for group therapy and counseling services using one therapist as determined by the department shall be used as the ceiling.

e. When therapy and counseling, restorative living skill development, and social or family skill development services are provided as a group service, the payment rates shall be determined by dividing the reasonable and necessary cost for that service by the average number of children or families in attendance at the group service.

441—185.107(234) Payment of new rates. New rates shall become effective according to the following four provider and service conditions.

185.107(1) *Rates based on reports of costs for the provider's fiscal year.* Providers shall submit the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, within three months of the close of the provider's fiscal year. This form shall be used to report all reasonable and necessary costs for the entire fiscal year. Rates shall be adjusted based on the reported costs and a new rate established effective for programs provided beginning no later than the first day of the second month after receipt by the project manager of a complete financial and statistical report. However, no rate shall be effective prior to the effective date of the contract for a program.

185.107(2) *Rates for new providers and current providers adding a new program.* Rates based on a projected budget or the first actual report shall be effective no later than the first day of the second month after receipt by the project manager of a complete financial and statistical report. The provider handbook shall specify the information to be completed for the projected budget. However, no rate shall be effective prior to the effective date of the contract for a program.

185.107(3) *Liability for payment.* The department shall not be liable for payment for any programs prior to the contract effective date.

185.107(4) *Utilization.* Utilization for new family-centered, family preservation and family foster care programs shall not be budgeted at less than 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program. Utilization for new group care programs shall not be budgeted at less than the following: Utilization for group care facilities certified to provide community residential treatment and licensed pursuant to 441—Chapter 116 or 481—Chapter 57 or 63 shall be 95 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program. Utilization for all other group care facilities certified to provide community residential treatment and group care facilities certified to provide comprehensive residential treatment or enhanced residential treatment shall be 90 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program. The new provider or current

provider adding a new program shall specify on the financial and statistical report the licensed capacity, when applicable, and the staffed capacity for each new program. Any changes in licensed or staffed capacity shall be reported on any subsequently submitted cost reports.

441—185.108(234) Conversion to fixed fee schedule. Rescinded IAB 11/5/97, effective 1/1/98.

441—185.109(234) Fiscal years 1997 and 1998 determination of rates. Rules 441—185.102(234) to 441—185.107(234) are held in abeyance for purposes of establishing rates effective during the time period beginning July 1, 1996, to June 30, 1998. The subrules set forth below shall be considered to comply with rule 441—185.108(234) for the time period they are in effect. Rates to be effective July 1, 1996, shall be established based on the rate in effect as of June 30, 1996, plus an index factor of 2 percent. Rates to be effective July 1, 1997, shall be established based on the rates in effect as of June 30, 1997. Any increases in rates to be effective July 1, 1997, shall be subject to availability of funding.

185.109(1) *New services.* When a new provider contracts to provide rehabilitative treatment or supportive services or an existing provider adds a new service, the rate for the new services shall be established based on the weighted average rate.

a. The weighted average rate to be effective for new services provided from July 1, 1996, to June 30, 1997, shall be calculated as specified in paragraph 185.109(1)*"b"* based on the rates in effect on July 1, 1996. The weighted average rate to be effective for new services provided on or after July 1, 1997, shall be the weighted average rate in effect for the previous year plus any index factor which has been applied for the establishment of rates for the time period July 1, 1997, to June 30, 1998.

b. The formula for calculation of the weighted average rate shall be as follows:

The weighted average shall be computed by multiplying the rate for each similar service in effect as of July 1, 1996, by the number of units of each service provided to department clients. The products shall be totaled and divided by the total number of units provided to department clients as reported on the most recently submitted financial and statistical reports on which rates were established. All financial and statistical report data shall be annualized to provide equitable treatment of all provider rates. Rates not established through the use of the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, shall not be considered when establishing the weighted average rate.

c. New rates shall only be established for services that a provider is not already providing. If a provider already has a rate for a similar service, the provider shall be required to use that rate for all similar services. If a provider has more than one rate for a similar service, the rate shall be the simple average of the rates in effect.

d. If there are less than four rates for a specific service, the department shall determine the rate for that service code by requiring financial and statistical reports reflecting the projected costs for the new service to be submitted in accordance with rules 441—185.102(234) to 441—185.107(234). When the costs are being submitted for a current provider adding a program not currently under a contract developed pursuant to 441—Chapter 152, the provider shall report the projected costs for the new service on a copy of the most recently submitted Financial and Statistical Report, Form 470-3049, on which rates have been established. This report shall show any adjustments to the Certification Page. The salary schedule, Schedule B, is to be adjusted on the correct line item for that position. Adjustments shall also be made to any line item on Schedule D-1 so that the dollar volume increase because of the new services is reflected on Schedule D-1.

The report of actual costs pursuant to paragraph 185.103(1)*"b"* shall be a report of costs only for the new service.

185.109(2) *Transition provisions.*

a. If a provider has submitted an annual financial and statistical report but no rate has been established based on that report, the rate to be in effect July 1, 1996, shall be the rate in effect June 30, 1996, plus the 2 percent index factor.

b. If a provider has submitted a first actual financial and statistical report, but no rate has been established based on that report, the rate to be in effect July 1, 1996, shall be the projected rate in effect June 30, 1996, plus the 2 percent index factor.

c. If a provider has submitted a projected budget but no rate has been established based on that budget, the rate to be effective July 1, 1996, shall be the weighted average rate.

d. If a provider has had a rate of zero due to lack of utilization, the rate shall be established using the weighted average rate for that service upon request from the provider and to be effective the first of the month following receipt of the request.

185.109(3) *Public agencies.* Public agencies shall comply with paragraph 185.106(3)*"d."*

185.109(4) *Interruptions in a program.* Interruptions in a program shall not affect the rate. If a provider assumes the delivery of a program from another provider, the rate shall remain the same as for the former provider. If a provider ceases to contract for and provide a service or program and later decides to again contract for and provide that program or service and has a contract for that service in effect within two years, the rate shall be established at the rate in effect when service was interrupted unless otherwise specified below. If the service was interrupted prior to July 1, 1996, and reinstated between July 1, 1996, and June 30, 1997, the rate shall be the rate in effect at the time of interruption plus 2 percent. If the service was interrupted prior to July 1, 1996, and the service is reinstated between July 1, 1997, and June 30, 1998, the rate shall be the rate in effect when the interruption occurred plus 2 percent and any index factor applied for rates effective July 1, 1997. If the service was interrupted after July 1, 1996, and is reinstated after July 1, 1997, the rate shall be the rate in effect when the interruption occurred and any index factor applied for rates effective July 1, 1997.

185.109(5) *Maintenance of fiscal records.* Subrules 185.102(1) to 185.102(3), rule 441—185.104(234), subrules 185.105(11) and 185.106(1), paragraph 185.106(3)*"d,"* and subrule 185.106(4) shall be used as the basis for maintenance of fiscal records.

185.109(6) *Certified audits.* Certified audits shall be conducted and the reports submitted to the department as set forth in subrule 185.102(4).

185.109(7) *Billing.* For billing purposes, subrule 185.106(4) remains in effect.

185.109(8) *Rates for services provided on or after July 1, 1998.* In absence of an alternative rate-setting methodology effective July 1, 1997, rules 441—185.102(234) to 441—185.107(234) shall be the basis of establishing rates to be effective for services provided on or after July 1, 1998.

a. In absence of a fixed fee schedule pursuant to rule 441—185.108(234) or other new rate-setting methodology set forth in rule, all providers, regardless of when their fiscal year ends, shall submit a Financial and Statistical Report, Form 470-3049, for the time period July 1, 1997, to December 31, 1997, based on the cost principles set forth in rule 441—185.101(234) to 441—185.107(234). This report shall be submitted no later than March 31, 1998. Rates based on reports submitted pursuant to this paragraph shall be effective no earlier than July 1, 1998, and no later than August 1, 1998, when the report is sufficient for the establishment of rates. However, if a provider with a contract in effect as of June 30, 1996, has a fiscal year which ends at the end of January, February, or March 1998, the provider shall submit the financial and statistical report for the time period July 1, 1997, through the end of the provider's fiscal year, 1998. The report shall be submitted no later than three months after the close of the provider's established 1998 fiscal year. Rates shall be effective no later than the first day of the second full month after receipt by the project manager of a complete financial and statistical report.

b. Failure by providers to submit the report within the established time frames without written approval from the chief of the bureau of purchased services or the chief's designee shall be cause to reduce the payment to 75 percent of the rate in effect June 30, 1998, or the weighted average rate as of July 1, 1997, whichever is less. Approval for an extension for the submission shall be granted only when the provider can demonstrate that there have been catastrophic circumstances prohibiting timely submission.

c. If an extension is granted, the rate in effect as of June 30, 1998, shall be continued until the new rate is established. If a new rate is not established by the date set forth by the chief of the bureau of purchased services or the chief's designee in the notice of approval of the request to extend the time frame for submission of the Financial and Statistical Report, Form 470-3049, the provider's rate in effect as of June 30, 1998, shall be reduced to 75 percent of the rate in effect June 30, 1998, or the weighted average rate as of July 1, 1997, whichever is less, until such time as the new rate can be established.

d. If a provider has submitted the report on time, but a rate cannot be established within four months of the original due date due to incomplete or erroneous information, payment shall be reduced to 75 percent of the rate in effect June 30, 1998, or the weighted average rate as of July 1, 1997, whichever is less, until such time as the new rate can be established.

e. All subsequent financial and statistical reports shall be submitted within the time frames established pursuant to subrule 185.103(1).

f. Rates for individual providers shall be established pursuant to subrule 185.103(7) with the exception of rates to be in effect July 1, 1998. Individual providers shall submit to the department the information required by

subrule 185.103(7) no later than March 31, 1998, to establish rates to be effective July 1, 1998. Rates shall be recalculated annually on the anniversary of the effective date of the contract from that point forward.

185.109(9) *Audit adjustments.* If the department or its authorized representatives conduct an audit and the audit findings result in exceptions to costs and adjustment to the rate in effect June 30, 1996, and the June 30, 1996, rate was the basis of the rate established effective July 1, 1996, the July 1, 1996, rate shall be adjusted in accordance with the audit findings.

185.109(10) *Liability for payment.* The department shall not be liable for payment for any programs or services prior to the contract effective date or the effective date for the rate for the program or service.

441—185.110(234) Providers under an exception to policy for establishing rates. When a provider has been granted an exception to rules 441—185.102(234) to 441—185.107(234) by the director prior to June 30, 1996, and the rate was established based on that exception by June 30, 1996, the exception shall continue in effect as written.

The rate in effect June 30, 1996, shall be frozen. The rate to be effective July 1, 1996, shall be the frozen rate plus a 2 percent index factor. If the rate based on the exception to policy was not established by June 30, 1996, the rate in effect as of June 30, 1996, shall be frozen and the rate to be effective July 1, 1996, shall be the frozen rate plus a 2 percent index factor. If the provider has a zero rate or no rate has been established for the service, the rate shall be established pursuant to subrule 185.109(1). However, for out-of-state providers with an exception to policy to establish rates based on the rates established by the state in which the provider is located, rates shall continue to be established in accordance with the existing exception to policy.

441—185.111(234) Data. The data to be used in calculating the fiscal impact of any proposed rules for a cost–based rate–setting methodology to become effective July 1, 1997, and to be used for the establishment of rates to be effective July 1, 1998, shall be the data from financial and statistical reports on which rates were established as of June 30, 1996.

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

441—185.112(234) Determination of rates. Rules 441—185.102(234) to 441—185.107(234), 185.109(234) and 185.110(234) shall be held in abeyance for purposes of establishing rates effective January 1, 1998, unless otherwise provided for in these rules. Rates for a service to be effective on or after February 1, 1998, shall be established based on the payment rate negotiated between the provider and the department. This negotiated rate shall be based upon the historical and future reasonable and necessary cost of providing that service, other payment-related factors and availability of funding. Negotiated rates may be increased without negotiation if funds are appropriated for an across-the-board increase. A rate in effect as of December 31, 1997, shall continue in effect until a negotiated rate is established in accordance with the requirements of subrules 185.112(1) to 185.112(3), 185.112(6), or 185.112(12), or a rate is established in accordance with subrule 185.112(14), or until the service is terminated in accordance with subrule 185.112(4).

185.112(1) *Negotiation of rates.* Rates for services to be made effective on or after February 1, 1998, must be established in accordance with this subrule except as provided for at subrule 185.112(12) or 185.112(14).

a. On or after January 1, 1998, the department shall begin negotiating payment rates with providers of rehabilitative treatment and supportive services to be effective for services provided on or after February 1, 1998.

b. The scope of these negotiations is limited solely to the rate to be paid for each service.

(1) No other items, such as, but not limited to, changes in staff qualifications, service definition, required components, allowable costs or any licensing, certification or any contract requirement can be the subject of negotiations or used as a basis for changing rates except as provided for at subparagraph 185.112(1)*"f"*(7).

(2) The initial negotiation of rates pursuant to rule 441—185.112(234) shall encompass all of the services in the existing rehabilitative treatment and supportive services contract.

c. The service area manager of the host area is responsible for the negotiation of rates for each provider whose contract for rehabilitative treatment and supportive services is administered by the host area, regardless of where services are provided.

(1) 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 service area will negotiate the rate for that service.

d. The service area manager of the host area and the provider are mutually responsible for initiating the rate negotiation process. Negotiations should begin no later than May 1, 1998. Negotiations may be conducted in a manner acceptable to both parties but shall be conducted face to face upon the request of either party.

e. The provider must disclose any and all relevant subcontractual and related party relationships related to the provision of rehabilitative treatment or supportive services at the initiation of the rate negotiation process.

(1) This disclosure shall include all current and any proposed subcontracts that relate to the direct provision of rehabilitative treatment or supportive services for which rates are being negotiated. The provider shall make a written statement disclosing any current or proposed subcontracts that may relate to the rehabilitative treatment and supportive services for which rates are being negotiated.

(2) This disclosure shall include all transactions with related parties as defined at paragraph 185.105(11)*"c"* or 441—subrule 152.2(18) that may relate to the rehabilitative treatment and supportive services for which rates are being negotiated. The provider shall make a written statement disclosing any current related party transactions that may relate to the rehabilitative treatment and supportive services for which rates are being negotiated. This disclosure is only required when either the department or the provider seeks to establish a rate different than the rate used as the starting point for rate negotiations.

(3) Failure by a provider to comply with these requirements shall be considered a violation in accordance with subrule 185.12(6) and may result in sanctions being imposed or the withholding of payments.

f. For those services with a nonzero payment rate in effect on December 31, 1997, the rate in effect on December 31, 1997, shall be used as the starting point for rate negotiations. For rates to be effective on or after February 1, 1998, the department and the provider by mutual written agreement may either leave the rate in effect as of December 31, 1997, at its current level or they may raise or lower the rate in effect as of December 31, 1997. Adjustment of the rate in effect as of December 31, 1997, shall be based on the following factors:

(1) Changes in the Consumer Price Index for all Urban Consumers (CPI-U). Any adjustment based on changes in the CPI-U shall not exceed the amount by which the CPI-U increased during the previous calendar year.

(2) Changes in a provider's allowable costs based on current actual cost data or documented projections of cost. Allowable costs are those costs not excluded pursuant to rule 441—185.104(234).

(3) Changes in program utilization that impact the per unit cost of a program. Rates shall not be adjusted based on utilization levels that are below the minimum effective utilization of 80 percent or actual (whichever is higher) of the licensed or staffed capacity (whichever is less) of the program. If actual utilization is used as a basis for adjusting a rate, the actual effective utilization for the 12-month period immediately preceding the initiation of rate negotiations shall be used.

(4) Changes in the department's expectations of where a service must be delivered.

(5) Changes proposed by a provider and agreed to by the department of where a service must be delivered.

(6) Loss of a grant by a provider when the grant amount had previously been used to offset expenses which had resulted in a lower rate for rehabilitative treatment and supportive services.

(7) Changes in state or federal laws, rules or regulations that result in a change in the costs attributable to the services in question, including minimum wage adjustments.

(8) Competitive factors between providers.

(9) Department funding availability.

g. Existing providers who currently have a contract to provide a service where the payment rate has been established at zero prior to January 1, 1998, may use the weighted average rate established pursuant to paragraph 185.112(2)*"c"* for that service in lieu of their existing rate as the starting point for negotiations unless they have a nonzero rate for a similar service. If a provider has a nonzero rate for a similar service, the starting point for rate negotiations shall be established pursuant to paragraph 185.112(2)*"a"* or *"b."*

h. Negotiated rates are subject to the following additional limitations.

(1) For public agencies, profit or other increment above cost is not allowed (see subrule 185.112(5)). For private entities there is no provision for or prohibition of profit in these rules.

(2) Rates for cotherapy services continue to be subject to the limitations specified at subparagraph 185.106(4)*"c"*(2).

(3) Rates shall not exceed any rate ceiling established or authorized by the legislature.

(4) Rates to be paid may not exceed the limits established by 441—subrule 152.2(17).

i. The basis for any and all changes from the rate used as the starting point for negotiations shall be documented. A copy of all documentation shall be attached to the Rehabilitative Treatment and Supportive

Services Negotiated Rate Establishment Amendment, Form 470-3404, when it is submitted to the bureau of purchased services for implementation.

j. Only the service area manager of the host area may approve the rates negotiated for a provider.

(1) This approval shall be based upon the historical cost basis used for establishing those rates and the documented factors justifying variation from those historical costs.

1. Payment rates in effect as of December 31, 1997, shall be considered to be sufficiently documented and no justification is required for continuing a rate in effect as of December 31, 1997.

2. Payment rates set at the weighted average rate for a service shall be considered to be sufficiently documented and no justification is required for establishing or maintaining a rate at the weighted average level.

(2) After both the provider and the service area manager of the host area have signed the Rehabilitative Treatment and Supportive Services Negotiated Rate Establishment Amendment, Form 470-3404, it shall be submitted to the bureau of purchased services along with the written disclosure required at paragraph 185.112(1)*"e"* and any necessary documentation to support changes in the rate from the historical cost base as required by paragraph 185.112(1)*"h."*

(3) The effective date of the rate for a new service shall be the effective date of a new contract or the effective date of the contract amendment adding that new service to an existing contract unless a later effective date is agreed to by both parties.

(4) The effective date of the rate for an existing service shall be the first of the month following the month in which the Rehabilitative Treatment and Supportive Services Negotiated Rate Establishment Amendment, Form 470-3404, and all necessary supportive documentation and disclosures are received by the bureau of purchased services by the fifteenth of the month.

k. Once a negotiated rate is established based on the provisions of this subrule, it shall not be changed or renegotiated during the period of this rule except in the following circumstances:

(1) By mutual consent of the provider and the service area manager of the host area based upon the factors delineated at paragraph 185.112(1)*"f,"* except that rates shall not be changed or renegotiated for the period of July 1, 2000, through June 30, 2009.

(2) In accordance with paragraph 185.112(6)*"b,"* except that rates shall not be changed or renegotiated for services not assumed by a new provider for the period of July 1, 2000, through June 30, 2009.

(3) Rates may be changed when funds are appropriated for an across-the-board increase. A 1 percent cost-of-living adjustment will be applied to those rates in effect as of June 30, 2008.

185.112(2) *New services.* When a new provider contracts to provide a rehabilitative treatment or supportive service or an existing provider adds a new rehabilitative treatment or supportive service on or after January 1, 1998, the rate for the new service shall be established based on a payment rate negotiated in accordance with subrule 185.112(1) using the weighted average rate for that service in lieu of an existing rate as the starting point for negotiations.

a. If an existing provider already has a rate for a similar service and wishes to establish a second rate for that service, the starting point for rate negotiations for the second rate shall be the starting point used in negotiations for the provider's already established rate for that similar service.

b. If an existing provider has more than one rate for a similar service and wishes to establish an additional rate for that service, the starting point for rate negotiations shall be established by the service area manager of the host area and shall be one of the following: the starting point of that provider's established rate for the similar service most closely resembling the proposed service, or the simple average of the starting points of all of the provider's established rates for similar services.

c. The weighted average rate is the weighted average rate for each service as of July 1, 1997, as previously established in accordance with subrule 185.109(1).

d. For those services where no weighted average rate has been established because there are less than four rates existing for that service or for newly developed rehabilitative treatment and supportive services, the department shall determine the cost of that service by requiring financial and statistical reports reflecting the costs for the new service to be submitted in accordance with rules 441—185.102(234) to 441—185.107(234). Initial projected rates established in accordance with this subrule shall become effective in accordance with subrule 185.107(2).

The report of actual costs pursuant to paragraph 185.103(1)*"b"* shall be used only to establish the historical costs of the new service which shall be used as the starting point in the rate negotiation process. The negotiated

rate established in accordance with subrule 185.112(1) based upon the actual cost report shall become effective in accordance with paragraph 185.112(1)*"j."*

185.112(3) *Rate resolution process.* The rate resolution process may be used when the department and a provider are unable to agree upon a rate for a service within 60 days of initiating rate negotiations.

a. This process involves obtaining an independent mediator who is agreeable to both parties.

b. The cost of the mediator shall be borne equally by the provider and the department. Neither party to the mediation shall be liable for paying for more than that party's share of the cost for eight hours of mediation unless this is mutually agreed upon prior to initiation of the mediation process.

c. The rate resolution process must be concluded within 60 days of its initiation.

d. The mediator shall not make rate-setting decisions. The role of the mediator is to facilitate discussions between the parties in an effort to help the parties reach a mutual agreement.

185.112(4) *Failure to reach agreement on rates.* In the event the department and the provider are unable to reach agreement on a rate, the following procedures apply:

a. If the department and an existing provider are unable to reach agreement on a negotiated rate for an existing service with a published rate within 60 days of initiating negotiations or by June 30, 1998, whichever comes first, the rate resolution process may be used.

(1) Whether or not the rate resolution process is used, if agreement is not reached by September 30, 1998, the service shall be deleted from the provider's rehabilitative treatment and supportive services contract no later than November 30, 1998.

(2) If agreement is reached, the rate shall become effective in accordance with the provisions of paragraph 185.112(1)*"i."*

b. In the event the department and an existing provider are unable to reach agreement on a rate for a new service or an existing service without a published rate within 60 days of initiating rate negotiations, the rate resolution process may be used.

(1) If the rate resolution process is not used, and agreement is not reached within 120 days of initiating negotiations, no rate shall be established.

1. For new services, any contract amendment associated with that rate shall be denied.
2. For existing services without a rate, the contract shall be amended to delete this service from the contract.

(2) If the rate resolution process is used and no rate is agreed upon within 60 days of referral to the rate resolution process, no rate shall be established.

1. For new services, any contract amendment associated with that rate shall be denied.
2. For existing services without a rate, the contract shall be amended to delete this service from the contract.
3. If agreement is reached within the required time frames in either of the above situations, the rate shall become effective in accordance with the provisions of paragraph 185.112(1)*"i."*

c. In the event the department and a new provider are unable to reach agreement on a rate for a service within 60 days of initiating rate negotiations, the rate resolution process may be used. If no rate is agreed upon within 60 days of initiation of the rate resolution process, no rate shall be established and the services in question shall not be a part of any approved contract for rehabilitative treatment and supportive services. In the event that the department and a new provider cannot reach agreement on any rates, the contract shall be denied.

d. In all cases, a service for which a negotiated rate has not been established in accordance with subrule 185.112(1), except as provided for at subrule 185.112(12), on or before September 30, 1998, shall be terminated from the provider's contract for rehabilitative treatment and supportive services no later than November 30, 1998.

e. The department shall not be liable for payment for any rehabilitative treatment or supportive service that does not have a rate established in accordance with subrule 185.112(1), except as provided for at subrule 185.112(12), that is provided after November 30, 1998.

185.112(5) *Public agencies.* Public agencies shall be required to demonstrate their compliance with paragraph 185.106(3)*"d."*

185.112(6) *Interruptions in a program.*

a. If a provider assumes the delivery of a program from a related party provider as defined at paragraph 185.105(11)*"c"* or 441—subrule 152.2(18), the rate for the new provider shall remain the same as the rate established for the former provider. The rate for the new provider shall also remain the same as for the former provider if the difference between the former and the new provider is a change in name or a change in the legal form of ownership (i.e., a change from sole proprietorship to corporation).

b. Except as provided in paragraph *"a"* above, when a new provider assumes the delivery of a program from another provider, all rates for the services previously provided by either provider shall need to be reviewed and may be renegotiated at the request of either party.

c. If a provider ceases to contract for and provide a service or program on or after July 1, 1996, and prior to establishing a negotiated rate in accordance with subrule 185.112(1), decides to again contract for and provide that program or service, the nonzero rate in effect when the contract ceased shall be used as a starting point in negotiating a new rate in accordance with subrule 185.112(1) for that service.

d. If an existing provider ceases to contract for and provide a service or program for which a zero rate has been established, and decides to again contract for and provide that program or service, the rate shall be established in accordance with subrule 185.112(2) and the starting point for negotiations shall be the weighted average rate.

e. If a provider ceases to contract for and provide a service or program after a rate has been established in accordance with subrule 185.112(1) and decides to again contract for and provide that program or service, the rate shall be established at the rate in effect when service was interrupted.

f. Rates for services interrupted prior to July 1, 1996, shall be treated as a new service in accordance with subrule 185.112(2).

185.112(7) *Maintenance of fiscal records.* Subrules 185.102(1) to 185.102(3), rule 441—185.104(234), subrules 185.105(11) and 185.106(1), paragraph 185.106(3)*"d,"* and subrule 185.106(4) shall be used as the basis for maintenance of fiscal records.

185.112(8) *Certified audits.* Certified audits shall be conducted and the reports submitted to the department as set forth in subrule 185.102(4).

185.112(9) *Billing.* Subrule 185.106(4) remains in effect for billing purposes.

185.112(10) *Rates for services provided on or after July 1, 2000.* Rescinded IAB 12/1/99, effective 2/1/00.

185.112(11) *Liability for payment.* The department shall not be liable for payment for any programs or services prior to the contract effective date or the effective date for the rate for the program or service.

185.112(12) *Providers under an exception to policy for establishing rates.* When a provider has been granted an exception to rules 441—185.102(234) to 441—185.107(234) or 441—185.109(234) by the director of the department prior to January 1, 1998, the exception shall continue in effect as written for any provider not located in the state of Iowa and for which the exception was based upon another state's requirement that providers be paid the same rate they are paid for clients from the provider's home state. The exceptions for all other providers shall terminate and the conditions leading to the exceptions being approved shall be considered in the rate establishment negotiations.

185.112(13) *Review of rate negotiations.* Rate negotiations are considered rate determinations and shall be handled in accordance with the provisions for rate determinations at rule 441—152.3(234). Requests for review of rate determinations shall be granted only if the rate resolution process as defined at subrule 185.112(3) has been used.

185.112(14) *Establishment of statewide fixed rates.* Rescinded IAB 7/2/08, effective 7/1/08.

441—185.113 to **185.120** Reserved.

DIVISION VII
BILLING AND PAYMENT PROCEDURES

441—185.121(234) 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 and each program. Complete invoices shall be sent to the department county office responsible for the client for approval and forwarding for payment.

Providers shall never bill for more than one month of service. A separate invoice is required for each separate month of service, even if the service span overlaps one month.

185.121(1) *Time limit for submitting invoices.* The time limit for submission of original invoices shall be 90 days from the date of service, except at the end of the state fiscal year when claims for services through June 30 are to be submitted by August 10.

185.121(2) *Resubmittals of rejected claims.* Valid claims which were originally submitted within the time limit specified in 185.121(1) but were rejected because of an error shall be resubmitted as soon as corrections can be made.

185.121(3) *Payment.* Within 60 days of the date of receipt of a valid invoice, the department shall make payment in full of all invoices concerning rehabilitative treatment and supportive services rendered to clients, provided the invoices shall be subject to audit and adjustment by the department.

441—185.122(234) Recoupment procedures. Public agencies that are reimbursed more than their actual costs are required to refund any excess to the department within four months of the end of their fiscal year. No provision for profit or other increment above cost is intended in OMB Circular A–87 for public agencies. Those public providers subject to this provision who fail to comply with this requirement shall be considered to be in violation of 185.12(1)*"r"* and subject to sanctions. Providers who do not refund any excess payments within six months of the end of their fiscal year shall be given notice in accordance with 185.12(6) and have any and all payments suspended or withheld in accordance with 185.12(7).

441—185.123 to **185.125** Reserved.

DIVISION VIII
OVERPAYMENT PROVISIONS

441—185.126(234) Calculation of overpayments. Overpayment amounts shall be calculated by multiplying the unit rate by the number of units of the service for which the provider received payment in error.

185.126(1) *Random sampling and extrapolation.* When random sampling and extrapolation are used, the overpayment shall be calculated in accordance with paragraph 185.13(2)*"e."*

185.126(2) *Special provisions for group care.* The procedures in this subrule shall be applied to any billing audits initiated on or after December 1, 2003.

a. Determining the amount of overpayment for each child. When the department identifies an overpayment in a community, comprehensive, or enhanced group care service as a result of a provider's failure to meet the requirements for group care therapy and counseling established in subrule 185.83(5) or failure to meet the requirements for group care skill development as established in subrule 185.83(1), 185.83(2), or 185.83(3), the amount of overpayment for that service for a child during a calendar month shall be calculated as follows:

(1) Multiply the number of days for which the skill development requirement for the client was not met (deficient skill development days) by the unit rate. This is the skill development overpayment amount.

(2) Subtract the number of deficient skill development days from the number of days for which the provider received payment. The number of days remaining, if any, shall be used to determine the number of hours of acceptable therapy and counseling required pursuant to subrule 185.83(5). Any acceptable therapy and counseling provided during deficient skill development days shall be counted toward the therapy and counseling minimum requirement.

(3) Determine whether the amount of acceptable therapy and counseling provided and documented for the client during the calendar month is less than the number of hours of therapy and counseling required for the number of days of group care paid for during the calendar month that remains after adjusting for skill development deficiencies. If so, subtract the amount of acceptable therapy and counseling provided and documented for the client during the calendar month from the number of hours of therapy and counseling required for the remaining number of days of group care paid for the client during the calendar month. Divide this remainder by the required number of hours of therapy and counseling for the remaining number of days of group care paid for the client during the calendar month. The result of this division, expressed as a percentage, is the therapy and counseling deficiency percentage.

(4) Subtract the skill development overpayment amount from the total payment for this service code for this child for this month.

(5) Multiply the remaining payment, if any, by the therapy and counseling deficiency percentage. The result is the therapy and counseling overpayment amount.

(6) Add the skill development overpayment amount to the therapy and counseling overpayment amount. The result is the total overpayment amount for the child for the service code for the calendar month.

b. Determining the total overpayment amount. Add the overpayment amounts for all clients for the service code for each calendar month together to determine the total overpayment amount.

(1) If extrapolation is not used, this amount is the total overpayment amount.

(2) If random sampling and extrapolation are used, then this amount is used to calculate the sample error payment rate in accordance with subparagraph 185.13(2)*"e"*(3). The sample error payment rate is then used to calculate the extrapolated overpayment.

c. Examples. The examples set forth below are designed to address only the overpayment calculation with respect to per diem service, and do not address overpayment calculations with respect to per diem maintenance, additional services or optional service. The following examples illustrate the calculation of the overpayment amount for per diem service on rehabilitative and supportive services group foster care audits:

EXAMPLE 1. The provider furnishes comprehensive residential treatment to Child A for the month of July. Child A was discharged on July 27, so the provider may bill for only 26 days of service for July. The provider has mistakenly billed for 31 days of service for July. The provider has billed a per diem rate of $90 for each day of service, representing a total billing for July of $2,790 ($90 x 31).

Upon audit, it is determined that the provider has properly documented skill development services for each of the days the child was present in the facility and has furnished five hours of therapy and counseling to Child A during July. The overpayment calculation with respect to Child A is as follows:

The erroneous billing for five days of service during the month results in an audit adjustment of $450 ($90 x 5). The requirement for therapy and counseling for the number of days of service for which the provider may bill (26) is six hours, but only five hours of therapy and counseling were provided, resulting in an error rate of 16.67 percent ((6 - 5) ÷ 6 = 16.67 percent).

This error rate is then multiplied by the difference between the total amount the provider billed for the month ($2,790) less the overpayment for the erroneous billing ($450). There is no audit adjustment for skill development since the required skill development was properly documented. Thus, the overpayment for therapy and counseling is $390 (($2,790 - $450) x 16.67 percent = $390).

The total overpayment amount is $840, the sum of the overpayment for the erroneous billing ($450) and the overpayment for therapy and counseling ($390).

EXAMPLE 2. The provider furnishes community residential group treatment to Child B for the month of August. A provider may bill for the day of admittance to the program if service provision requirements for that day are otherwise satisfied. Since Child B was admitted to the program on August 14, Child B was present in the program for 18 days during the month. The provider has billed a per diem rate of $75 for each day of service, representing a total billing for August of $1,350 ($75 x 18).

Upon audit, it is determined that the provider failed to document the provision of skill development for two of the days during the service period during the month and that the provider has furnished 1.5 hours of therapy and counseling to Child B during August. The overpayment calculation with respect to Child B is as follows:

The failure to document the provision of skill development for two days of service during the month results in an audit adjustment for skill development of $150 ($75 x 2).

The requirement for therapy and counseling for the number of days of service for which the provider may bill (16) is two hours, but only 1.5 hours of therapy and counseling were provided, resulting in an error rate of 25 percent ((2 - 1.5) ÷ 2 = 25 percent). This error rate is then multiplied by the difference between the total amount billed by the provider for the month ($1,350) less the overpayment determined for skill development ($150). Thus, the overpayment for therapy and counseling is $300 (($1,350 - $150) x 25 percent = $300).

The total overpayment amount is $450, the sum of the overpayment for skill development ($150) and the overpayment for therapy and counseling ($300).

EXAMPLE 3. The provider furnishes enhanced residential treatment to Child C for the month of September. Child C is present in the program from the beginning of the month until discharged from the program on September 16. Since a provider may not bill for the day of discharge, the provider bills for 15 days of service for the month. The provider has billed a per diem rate of $100 for each day of service, representing a total billing for September of $1,500 ($100 x 15).

Upon audit, it is determined that the provider has documented the required skill development for the month and has furnished four hours of therapy and counseling to Child C during September. The overpayment calculation with respect to Child C is as follows:

There is no audit adjustment for skill development since the required skill development was properly documented.

The requirement for therapy and counseling for the number of days of service for which the provider may bill (15) is six hours, but only four hours of therapy and counseling were provided, resulting in an error rate of 33.33

percent ((6 - 4) ÷ 6 = 33.33 percent). This error rate is then multiplied by the difference between the total amount the provider billed for the month ($1,500) less the overpayment determined for skill development ($0). Thus, the overpayment for therapy and counseling is $500 (($1,500 - $0) x 33.33 percent = $500).

The total overpayment amount is $500, the sum of the overpayment for skill development ($0) and the overpayment for therapy and counseling ($500).

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93][1]
[Filed emergency 8/12/93—published 9/1/93, effective 8/12/93][11]
[Filed emergency 10/14/93—published 11/10/93, effective 11/1/93]
[Filed 12/16/93, Notices 9/1/93, 11/10/93—published 1/5/94, effective 3/1/94]
[Filed 3/10/94, Notice 1/19/94—published 3/30/94, effective 6/1/94]
[Filed emergency 5/11/94 after Notice 3/16/94—published 6/8/94, effective 6/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
[Filed emergency 12/15/94—published 1/4/95, effective 2/1/95]
[Filed emergency 2/16/95 after Notice 12/7/94—published 3/15/95, effective 2/16/95]
[Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 4/13/95, Notice 2/15/95—published 5/10/95, effective 7/1/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95][2]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 8/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 6/1/97]
[Filed 5/14/97, Notice 3/26/97—published 6/4/97, effective 8/1/97]
[Filed 10/15/97, Notices 7/30/97, 8/13/97—published 11/5/97, effective 1/1/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 1/13/99, Notices 11/18/98, 12/2/98—published 2/10/99, effective 3/17/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 7/14/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
[Filed 3/8/00, Notice 1/26/00—published 4/5/00, effective 6/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed 10/11/00, Notice 9/6/00—published 11/1/00, effective 1/1/01]
[Filed emergency 5/9/01—published 5/30/01, effective 5/9/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 7/11/01, Notice 5/30/01—published 8/8/01, effective 10/1/01]◊
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
[Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
[Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 12/16/03—published 1/7/04, effective 1/1/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed 5/14/04, Notice 1/7/04—published 6/9/04, effective 7/14/04]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]

[Filed 3/11/05, Notice 1/5/05—published 3/30/05, effective 6/1/05]
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed 10/21/05, Notices 5/11/05, 7/6/05—published 11/9/05, effective 12/14/05]
[Filed emergency 4/17/06 after Notice 3/1/06—published 5/10/06, effective 5/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 10/12/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06 after Notice 11/8/06—published 1/3/07, effective 1/1/07]
[Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

◊ Two or more ARCs

1 Rule 185.4(234), subrule 185.8(4) and rule 185.9(234), effective 8/12/93.

2 Effective date of 185.22(1)*"d,"*(2)*"d,"* and (3)*"d,"* 185.42(3), 185.62(1)*"d,"*(2)*"d,"* and (3)*"d,"* and 441—185.82(234) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 11, 1995.

RACING AND GAMING COMMISSION[491]

[Prior to 11/19/86, Chs 1 to 10, see Racing Commission[693]; Renamed Racing and Gaming Division [195] under the "umbrella" of Commerce, Department of [181], 11/19/86]
[Prior to 12/17/86, Chs 20 to 25, see Revenue Department[730] Chs 91 to 96]
[Transferred from Commerce Department[181] to the Department of Inspections and Appeals "umbrella"[481] pursuant to 1987 Iowa Acts, chapter 234, section 421]
[Renamed Racing and Gaming Commission[491], 8/23/89; See 1989 Iowa Acts, ch 67 §1(2), and ch 231 §30(1), 31]

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OCCUPATIONAL AND VENDOR LICENSING

[Prior to 11/19/86, Racing Commission[693]]
[Prior to 11/18/87, Racing and Gaming Division[195]]

491—6.1(99D,99F) Definitions.

"Applicant" means an individual applying for an occupational license.

"Beneficial interest" means any and all direct and indirect forms of ownership or control, voting power, or investment power held through any contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise.

"Board" means either the board of stewards or the gaming board, as appointed by the administrator, whichever is appropriate. The administrator may serve as a board of one.

"Commission" means the Iowa racing and gaming commission.

"Commission representative" means a gaming representative, steward, or any person designated by the commission or commission administrator.

"Conviction" means the act or process of judicially finding someone guilty of a crime; the state of a person's having been proved guilty; the judgment that a person is guilty of a crime or criminal offense, which includes a guilty plea entered in conjunction with a deferred judgment, and a juvenile who has been adjudicated delinquent. The date of conviction shall be the date the sentence and judgment is entered.

"Deceptive practice" means any deception or misrepresentation made by the person with the knowledge that the deception or misrepresentation could result in some benefit to the person or some other person.

"Facility" means an entity licensed by the commission to conduct pari-mutuel wagering or gaming operations in Iowa.

"Jockey" means a person licensed to ride a horse in a race.

"Kennel/stable name " means any type of name other than the legal name or names used by an owner or lessee and registered with the commission.

"Licensee" means a person licensed by the commission to perform an occupation which the commission has identified as requiring a license for a person to work in the pari-mutuel, gambling structure, or excursion gambling boat industry in Iowa.

"Occupation" means a license category listed on the commission's occupational license application form.

"Owner" means a person or entity that holds any title, right or interest, whole or partial, in a racing animal.

"Rules" means the rules promulgated by the commission to regulate the racing and gaming industries.

"Theft" includes, but is not limited to:

1. The act of taking possession or control of either facility property or the property of another without the express authorization of the owner;
2. The use, disposition, or destruction of property in a manner which is inconsistent with or contrary to the owner's rights in such property;
3. Misappropriation or misuse of property the person holds in trust for another; or
4. Any act which constitutes theft as defined by Iowa Code chapter 714. No specific intent requirement is imposed by rule 6.5(99D,99F) nor is it required that there be any showing that the licensee received personal gain from any act of theft.

"Year" means a calendar year.

491—6.2(99D,99F,252J) Occupational licensing.

6.2(1) All persons participating in any capacity at a racing or gaming facility, with the exception of certified law enforcement officers while they are working for the facility as uniformed officers, are required to be properly licensed by the commission.

a. License applicants under 70 years of age may be required to furnish to the commission a set of fingerprints and may be required to be refingerprinted or rephotographed periodically.

b. License applicants must supply current photo identification and proof of their social security number and date of birth.

c. License applicants must complete and sign the application form prescribed and published by the commission. An incomplete application shall not be processed. The application shall state the full name, social security number, residence, date of birth, and other personal identifying information of the applicant that the

commission deems necessary. The application shall include, in part, whether the applicant has any of the following:

(1) A record of conviction of a felony or misdemeanor, including a record involving the entry of a deferred judgment and adjudications of delinquency;

(2) An addiction to alcohol or a controlled substance;

(3) A history of mental illness or repeated acts of violence;

(4) Military convictions;

(5) Adjudication of delinquency; or

(6) Overdue income taxes, fines, court-ordered legal obligations, or judgments.

d. License applicants for designated positions of higher responsibility may be required to complete a division of criminal investigation (DCI) background form.

e. A fee set by the commission shall be assessed to each license applicant. Once a license is issued, the fee cannot be refunded.

f. License applicants must pay an additional fee set by the Federal Bureau of Investigation (FBI) and by the department of public safety (DCI and bureau of identification) to cover the cost associated with the search and classification of fingerprints.

g. All racing and gaming commission fees for applications or license renewals must be paid by applicants or licensees before a license will be issued or renewed or, if the applicant is an employee of a facility, the commission fees will be directly billed to the facility.

h. An applicant who knowingly makes a false statement on the application is guilty of an aggravated misdemeanor.

i. Participation in racing and gaming in the state of Iowa is a privilege and not a right. The burden of proving qualifications to be issued any license is on the applicant at all times. An applicant must accept any risk of adverse public notice, embarrassment, criticism, or other action, as well as any financial loss that may result from action with respect to an application.

j. All licenses are conditional until completion of a necessary background investigation including, but not limited to, fingerprint processing through the DCI and the FBI and review of records on file with national organizations, courts, law enforcement agencies, and the commission.

k. Any licensee who allows another person use of the licensee's license badge for the purpose of transferring any of the benefits conferred by the license may be fined, have the license suspended or revoked, or be subject to any combination of the above-mentioned sanctions. No license shall be transferable and no duplicate licenses shall be issued except upon submission of an application form and payment of the license fee.

l. It shall be the affirmative responsibility and continuing duty of each applicant to provide all information, documentation, and assurances pertaining to qualifications required or requested by the commission or commission representatives and to cooperate with commission representatives in the performance of their duties. A refusal by any person to comply with a request for information from a commission representative shall be a basis for fine, suspension, denial, revocation, or disqualification.

m. Non-U.S. citizens must supply documentation authorizing them to work in the United States or supply documentation demonstrating compliance with the North American Free Trade Agreement.

n. Portions of all completed applications accepted by the commission are confidential. The following persons have the explicit right to review all information contained on the application: the applicant, all commission officials and employees, the track steward, and DCI agents or other law enforcement officers serving in their official capacity.

o. A license may not be issued or held by an applicant who is unqualified, by experience or otherwise, to perform the duties required.

p. A license may not be issued to applicants who have not previously been licensed in the following occupations except upon recommendation by the commission representative: trainers, assistant trainers, jockeys, apprentice jockeys, exercise persons, and other occupations the commission may designate. The commission representative may, for the purpose of determining a recommendation under this subrule, consult a representative of the facility, horsemen, or jockeys.

6.2(2) All facility board members shall undergo a background investigation and be licensed immediately upon appointment.

6.2(3) Multiple license restrictions.

a. A person may work outside the licensed occupation as long as the person is licensed in an equal or higher occupation.

b. In horse racing only, the following restrictions apply:

(1) A person licensed as a jockey or veterinarian may not be licensed in another capacity.

(2) A person may not be licensed as an owner and a jockey agent.

(3) No racing official may serve or act in another capacity at a race meeting at which that person is licensed as an official except if there is no conflict of interest or duties as determined by the commission representative.

6.2(4) Application endorsements. The responsibility of licensing an employee rests with the employer. Therefore, a license may not be issued to any employee unless the application includes prior endorsement of the facility's authorized representative. All facilities must submit a list of representatives authorized to sign applications. This list shall not exceed six names. This authorization list shall be sent to the commission licensing office associated with each facility.

6.2(5) An applicant who has not held a license for the previous calendar year shall be considered a first-time applicant.

6.2(6) Interim identification badge.

a. All interim identification badges issued by a facility must be recorded in a logbook, which is available for inspection by commission or DCI representatives. The logbook must reflect the following information: date issued; user's name and date of birth (verified by photo ID); occupation; badge number; issuer; time issued; and time returned. Badges shall only be issued on a daily basis and must be returned before the employee leaves facility premises. A badge shall be effective only until the commission licensing office's next day of business, and may not be used to avoid obtaining a duplicate license.

b. A badge shall only be issued if:

(1) An employee is hired during a time that the commission licensing office is closed; or

(2) An employee is not in possession of the employee's occupational license.

491—6.3(99D,99F) Waiver of privilege. An applicant may claim a privilege afforded by the Constitution of the United States or of the state of Iowa in refusing to answer questions of the commission. However, a claim of privilege with respect to any testimony or evidence pertaining to an application may constitute sufficient grounds for denial.

491—6.4(99D,99F) License acceptance.

6.4(1) *Occupational license (license).* The license shall be displayed in a conspicuous manner on the licensee's clothing at all times while the licensee is on duty unless otherwise permitted by the commission representative. A licensee is prohibited from defacing, altering, or modifying a license.

6.4(2) *Knowledge of rules.* By acceptance of a license from the commission, the licensee agrees to follow and comply with the rules of the commission and Iowa statutes pertaining to racing and gaming, to report immediately to the commission representative any known irregularities or wrongdoing involving racing or gaming and to cooperate in subsequent investigations. Commission rules are available on the commission's Web site at www.iowa.gov/irgc/.

6.4(3) *Search and seizure.* Acceptance of a license from the commission by any licensee is deemed consent to search and inspection by a commission or DCI representative and to the seizure of any prohibited medication, drugs, paraphernalia or devices.

6.4(4) *Misuse of license.* No person shall exercise or attempt to exercise any of the powers, privileges, or prerogatives of a license unless and until the appropriate licensing form has been executed and filed with the commission except under subrule 6.2(6). The commission shall exercise the power to regulate the conduct of all persons holding licenses or participating in racing or gaming.

491—6.5(99D,99F) Grounds for denial, suspension, or revocation of a license or issuance of a fine. The commission or commission representative shall deny an applicant a license or, if already issued, a licensee shall be subject to probation, fine, suspension, revocation, or other disciplinary measures, if the applicant or licensee:

6.5(1) Does not qualify under the following screening policy:

a. Applicants must be at least 18 years of age to work in areas where gaming or wagering is conducted.

b. Applicants must be at least 16 years of age to be eligible to be licensed to work for a trainer of racing animals.

c. A license shall be denied if an alias was used in connection with fraud within the last five years.

d. A license shall be denied if, within the last five years, an applicant has had a felony conviction or an offense involving theft or fraudulent practice in excess of $500, including a conviction involving the entry of a deferred judgment and adjudications of delinquency. If the conviction did not occur within the last five years, a license shall not be issued unless the commission representative determines that sufficient evidence of rehabilitation exists.

e. A license shall be denied if an applicant has a conviction of a serious or aggravated misdemeanor, including a conviction involving the entry of a deferred judgment and adjudications of delinquency, or the equivalent unless the commission representative determines that sufficient evidence of rehabilitation exists.

f. A license shall be denied if an applicant has multiple convictions of simple misdemeanors, including those involving the entry of a deferred judgment and adjudications of delinquency, or alcohol-related offenses unless the commission representative determines that sufficient evidence of rehabilitation exists. In making that determination, the number of violations shall be considered.

g. A license may be denied if the applicant has been guilty of multiple offenses. The commission representative shall use the representative's judgment in making such a determination.

h. A license shall be temporarily denied or suspended until the outcome of any pending charges is known if conviction, including a conviction involving the entry of a deferred judgment and adjudications of delinquency, would disqualify the applicant.

i. A license shall be denied if the applicant has a current addiction to alcohol or a controlled substance, has a history of mental illness without sufficient evidence of rehabilitation, or has a history of repeated acts of violence without sufficient evidence of rehabilitation.

j. A license may be temporarily denied or a probationary license may be issued until outstanding, overdue court-ordered obligations are satisfied. These include, but are not limited to, criminal or civil fines, state or federal taxes, or conditions imposed upon a person by a court of law that the applicant has failed to meet in a timely manner.

k. A license shall be denied if an applicant owns, operates, or has an interest in any bookmaking or other illegal enterprise, or is or has been connected with or associated with any illegal enterprise within the past five years. If the applicant's association with the illegal enterprise occurred more than five years prior to the application, a license may be issued only if the commission representative determines that sufficient evidence of rehabilitation exists.

l. A license may be denied if an applicant is ineligible to participate in gaming in another state and it would not be in the best interest of racing or gaming to license the applicant in Iowa. A license shall be denied if an applicant is ineligible to participate in racing in another state whose regulatory agency is recognized by and reciprocates in the actions of this state.

m. A license shall be denied if an applicant has been denied patron privileges by order of this commission and not reinstated.

n. A license shall be denied if the applicant falsifies the application form and would be ineligible for licensure under paragraphs *"a"* through *"m"* above. In other cases of falsification, a license may be issued and the applicant shall be subject to a suspension, fine, or both.

o. A license shall be denied if an applicant is not of good repute and moral character. Any evidence concerning a licensee's current or past conduct, dealings, habits, or associations relevant to that individual's character and reputation may be considered. The commission representative shall decide what weight and effect evidence shall have in the determination of whether there is substantial evidence that the individual is not of good reputation and character. Applicants who hold positions of higher responsibility may be held to a more stringent standard of conduct and reputation than others with a less significant interest or role.

6.5(2) Has not demonstrated financial responsibility or has failed to meet any monetary obligation in the following circumstances connected with racing or gaming:

a. Issuance or passing of bad checks. No person shall write, issue, make, or present any check in payment for any license fee, nomination fee, entry fee, starting fee, or purse payment when that person knows or should reasonably know that the check will be refused for payment by the bank upon which it is written, or that the account upon which it is written does not contain sufficient funds for payment of the check, or that the check is written on a closed or nonexistent account.

b. Judgments. Whenever any person licensed to engage in racing suffers a final judgment entered against that person in any court of competent jurisdiction within the United States, when that judgment is based wholly

upon an indebtedness incurred by that person for supplies, equipment, or services furnished in connection with racing, the commission representatives shall schedule a hearing at which the licensee shall be required to show cause as to why the license should not be suspended.

c. Timely payment. Should an owner fail to make timely payment of any jockey fee, nomination fee, entry fee, starting fee, or any other reasonable charge normally payable to the facility, the facility shall notify the commission representatives who shall in turn give notice to the owner that a hearing will be held where the owner will be required to show cause why the license should not be suspended for failure to make the required payments.

6.5(3) Has been involved in any fraudulent or corrupt practices, including, but not limited to:

a. Offering, promising, giving, accepting, or soliciting a bribe in any form, directly or indirectly, to or by a person licensed by the commission to violate these rules or the laws of the state related to racing or gaming.

b. Failing to report any bribe or solicitation as in 6.5(3)*"a"* above.

c. Soliciting by any licensee, except the facility, of bets by the public.

d. Violation of any law of the state or rule of the commission, or aiding or abetting any person in the violation of any such law or rule.

e. Theft or deceptive practice of any nature on the premises of a facility.

f. Giving under oath any false statement or refusing to testify, after proper notice, to the commission representative about any matter regulated by the commission, except in the exercise of a lawful legal privilege.

g. Failing to comply with any request for information or any order or ruling issued by the commission representative pertaining to a racing or gaming matter.

h. Disorderly or offensive conduct; use of profane, abusive, or insulting language to, or interference with, commission representatives or racing or gaming officials while they are discharging their duties.

i. Conduct in Iowa or elsewhere has been dishonest, undesirable, detrimental to, or reflects negatively on, the integrity or best interests of racing and gaming.

j. Illegal sale, possession, receipt, or use of a controlled substance or drug paraphernalia; intoxication; use of profanity; fighting; making threatening or intimidating statements; engaging in threatening or intimidating behavior; or any conduct of a disorderly nature on facility premises.

k. Discontinuance of or ineligibility for activity for which the license was issued.

l. Possessing a firearm on facility property without written permission from the commission representative.

m. Improperly influencing or attempting to improperly influence the results of a race or a gambling game, singularly or in combination with any person.

n. Failing to report any attempt to improperly influence the result of a race or a gambling game as in 6.5(3)*"m"* above.

o. Having had two rulings related to attempts to affect a race result or odds (rulings for electrical devices, serious positives, for example) in a lifetime or one ruling within the last three years. A license may be issued if one ruling has occurred outside of three years if sufficient evidence of rehabilitation exists. A license may be denied if a lengthy record of rulings from other jurisdictions exists.

p. Possessing any equipment for hypodermic injection, any substance for hypodermic administration, or any container designed to hold an injectable substance (narcotics, medications, drugs, or substances which could be used to alter the speed of racing animals) by anyone other than a veterinarian licensed by the commission. Notwithstanding the provisions of this subrule, any person may have possession of any chemical or biological substance for the person's own treatment within a restricted area, provided that, if the chemical substance is prohibited from being dispensed without a prescription by any federal law or law of this state, the person is in possession of documentary evidence that a valid prescription has been issued to the person. Notwithstanding the provisions of this subrule, any person may have in possession within any restricted area any hypodermic syringe or needle for the purpose of self-administering to the person a chemical or biological substance, provided that the person has notified the commission representatives of the possession of the device, the size of the device, and the chemical substance to be administered and has obtained written permission for possession and use from the commission representative. A restricted area is a designated area for sample collection, paddock, racetrack, or any other area where officials carry out the duties of their positions.

q. Subjecting an animal to cruel and inhumane treatment by failing to supply it with adequate food, water, medical treatment, exercise, bedding, sanitation, and shelter; or by neglect or intentional act causing an animal to suffer unnecessary pain.

r. Offering or receiving money or other benefit for withdrawing a racing animal from a race.

s. Making a wager for a jockey by any person other than the owner or trainer of the horse ridden by the jockey.

t. Making a wager for a jockey on a horse by an owner or trainer other than that ridden by the jockey. This shall not be construed to include bets on another horse in combination with the horse ridden by the jockey in multiple wagering bets.

u. Offering or giving a jockey money or other benefit concerning a race, except by the owner or trainer of the horse to be ridden.

v. Entering or starting a racing animal known or believed to be ineligible or disqualified.

w. Possessing any device designed to increase or decrease the speed of a racing animal during a race other than an ordinary riding whip without written permission from the commission representative.

491—6.6(99D,99F) Applications for license after denial, revocation, or suspension.

6.6(1) Any person whose license was denied or revoked may reapply for a license in accordance with the commission's rules governing applications. However, the applicant must satisfy the following conditions:

a. The applicant shall bear the burden of proof of establishing satisfaction with all license criteria and shall provide proof of satisfaction of any terms or conditions imposed as a part of the commission's order denying or revoking the license;

b. The applicant shall allege facts and circumstances establishing, to the commission's satisfaction, sufficient evidence of rehabilitation and that the basis for the denial or revocation no longer exists;

c. The applicant shall establish that the public interest and the integrity of racing and gaming would not be adversely affected if a license is granted; and

d. If the license was revoked, a new application shall not be filed until five years have elapsed from the date of the order of revocation.

6.6(2) Any person whose license was suspended for 365 days may file a new application for a license upon the expiration of the period of suspension but must satisfy all of the conditions set forth in 6.6(1)*"a," "b,"* and *"c"* above. If a person's license has not expired after the 365-day suspension, the person must have a hearing before a board to determine if the person has satisfied all of the conditions set forth in 6.6(1)*"a," "b,"* and *"c"* above prior to that individual's participating in racing or gaming.

491—6.7(99D,99F) Probationary period placed on a license. The commission representative or the board may place a probationary period on a license. The terms of the probationary period shall include the effective dates, conditions placed on the licensee and any penalty for failure to follow those conditions, including fine, suspension, denial, or revocation.

491—6.8(99D,99F) Duration of license. A license issued by the commission is valid for two calendar years. The license shall expire at the end of the second calendar year, unless an extension is granted by the administrator.

491—6.9(99D,99F) Licensed employees moving from one location to another.

6.9(1) Once an applicant obtains an occupational license from the commission and is in good standing, the applicant is eligible to work at any of the facilities in the state of Iowa.

6.9(2) When a facility hires a person who is already in possession of a current occupational license, a list of the person(s) hired must be filed weekly with the local commission office. The list should contain the license number, name, social security number, and birth date of each person hired.

491—6.10(99D,99F) Required report of discharge of licensed employee. Upon discharge of any licensed employee by any licensed employer for violation of rules or laws within the jurisdiction of the commission, the employer must report that fact in writing, within 72 hours, to the local commission office including the name and occupation of the discharged licensee.

491—6.11(99D,99F,252J) Receipt of certificate of noncompliance from the child support recovery unit.

6.11(1) Upon the commission's receipt of a certificate of noncompliance, a commission representative shall initiate procedures for the suspension, revocation, or denial of issuance or renewal of licensure to an individual. A notice of intended action shall be served by restricted certified mail, return receipt requested, or by personal service in accordance with Iowa Rule of Civil Procedure 1.305.

6.11(2) The effective date of suspension or revocation, or denial of the issuance or renewal of a license, as specified in the notice, shall be no sooner than 30 days following service of the notice upon the licensee or applicant.

6.11(3) The filing of a district court action by a licensee or applicant challenging the issuance of a certificate of noncompliance shall automatically stay any administrative action. Upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the commission, the intended action will proceed as described in the notice. For purposes of determining the effective date of suspension or revocation, or denial of the issuance or renewal of a license, only the number of days before the action was filed and the number of days after the action was disposed of by the court will be counted.

6.11(4) Upon receipt of a withdrawal of a certificate of noncompliance from the child support recovery unit, the commission representative shall immediately reinstate, renew, or issue a license if the individual is otherwise in compliance with licensing requirements.

6.11(5) All commission fees for applications or license renewals must be paid by licensees or applicants before a license will be issued or renewed.

491—6.12(99D,99F,261) Receipt of a certificate of noncompliance from the college student aid commission.

6.12(1) Upon the commission's receipt of a certificate of noncompliance, a commission representative shall initiate procedures for the suspension, revocation, or denial of issuance or renewal of licensure to an individual. A notice of intended action shall be served by restricted certified mail, return receipt requested, or by personal service in accordance with Iowa Rule of Civil Procedure 1.305.

6.12(2) The effective date of the suspension or revocation, or denial of the issuance or renewal of a license, shall be no sooner than 30 days following service of the notice upon the licensee or applicant.

6.12(3) The filing of a district court action by a licensee or applicant challenging the issuance of a certificate of noncompliance shall automatically stay any administrative action. Upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the commission, the intended action will proceed as described in the notice. For purposes of determining the effective date of suspension or revocation, or denial of the issuance or renewal of a license, only the number of days before the action was filed and the number of days after the action was disposed of by the court will be counted.

6.12(4) Upon receipt of a withdrawal of a certificate of noncompliance from the college student aid commission, the commission representative shall immediately reinstate, renew, or issue a license if the individual is otherwise in compliance with licensing requirements.

6.12(5) All commission fees for applications or license renewals must be paid by licensees or applicants before a license will be issued or renewed.

491—6.13(99D,99F) Vendor's license.

6.13(1) A vendor's license is required of any entity not licensed as a manufacturer or distributor that conducts operations on site at a facility.

6.13(2) An applicant for a vendor's license must complete the appropriate commission form. An authorized representative from the facility for which the vendor wishes to do continuous business must sign the form. A letter from the facility authorizing the vendor to do business shall replace a signature on the application form.

6.13(3) Any employee who works for a licensed vendor and will be supplying the goods or services to the facility must have a vendor employee license. A vendor license must be issued before a vendor employee can be issued a license to represent that company. The authorized signature on the vendor employee's application must be the signature of the person authorized by the vendor application to sign vendor employee applications.

6.13(4) Rescinded IAB 9/29/04, effective 11/3/04.

491—6.14(99D,99F) Applicability of rules—exceptions. Rules pertaining to and rulings against licensees shall apply in like force to the spouse and members of the immediate family or household of the licensee if the continuation of participation in racing or gaming by the affected person circumvents the intent of the rule or affects the ruling by permitting a person under the control or direction of the licensee to serve in essence as a substitute for a suspended licensee, or a person ineligible to participate in a particular activity.

491—6.15(99D) Disclosure of ownership of racing animals. All entities of ownership (individual, lessee, lessor, general partnership, or corporation) and all trainers are responsible for making full and accurate disclosure of the ownership of all racing animals registered or entered for racing. Disclosure shall identify in writing all individuals

or entities that, directly or indirectly, through a contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise hold any interest in a racing animal, and those individuals or entities who by virtue of any form of interest might exercise control over the racing animal or may benefit from the racing of the animal. The degree and type of ownership held by each individual person shall be designated. The transfer of a racing animal to avoid application of a commission rule or ruling is prohibited and constitutes grounds for discipline.

491—6.16(99D) Owners of racing animals.

6.16(1) Each greyhound owner must obtain an owner's license from the commission to enter an animal in an official schooling race or a purse race at an Iowa racetrack.

6.16(2) Each owner is subject to the laws of Iowa and the rules promulgated by the commission immediately upon acceptance and occupancy of accommodations from or approved by a facility or upon making entry to run on its track. Owners shall accept the decision of the commission representative on any and all questions, subject to the owner's right of appeal to the commission.

6.16(3) An owner who is under the age of 18 must have a parent or guardian cosign any contractual agreements.

6.16(4) No person or entity that is not the owner of record of a properly registered racing animal that is in the care of a licensed trainer may be licensed as an owner.

6.16(5) Temporary horse owner license.

a. A temporary horse owner license may be issued at the discretion of the commission representative.

b. Any temporary horse owner license shall be effective for 15 calendar days from the date of issuance and shall be valid for a maximum of one start per horse in an official race.

c. Failure to obtain a permanent license within the designated 15 calendar days will result in forfeiture of the license fee. Failure to obtain a permanent license may also result in the automatic disqualification from license eligibility and may result in a fine or suspension for the licensee that has failed to comply.

d. Purses shall not be paid to the owner of any racing animal holding a temporary horse owner license. Payments shall be permitted only after the individual has obtained a permanent license.

e. The owner (includes stable names, partnerships, and corporations) and trainer of a horse must be licensed at least one hour before post time of the race in which the horse is entered. In the case of absentee owners, the trainer must submit a properly executed temporary horse owner license application on behalf of the absentee owner(s) at least one hour before post time of the race in which the horse is entered.

491—6.17(99D) Kennel/stable name.

6.17(1) Licensed owners and lessees wishing to race under a kennel/stable name may do so by applying for a license with the commission on forms furnished by the commission. All kennel/stable names must be licensed with the commission on forms furnished by the commission, and in accordance with the requirements of 491—6.16(99D).

6.17(2) A kennel/stable name license is only necessary if the kennel/stable name is a name other than the licensed owner's legal name (first and last name), the owner's full name followed by the word "kennel" or "stable," or a licensed partnership or corporation.

6.17(3) In applying to race under a kennel/stable name, the applicant must disclose the identities behind the name and, if applicable, comply with partnership and corporation rules. The application form must appoint one person to act as the agent for the kennel/stable name.

6.17(4) Changes in identities involved in a kennel/stable name must be reported immediately to and approved by the commission representative.

6.17(5) A licensed owner who has registered under a kennel/stable name may at any time cancel the kennel/stable name after giving written notice to the commission.

6.17(6) A kennel/stable name may be changed by registering a new name.

6.17(7) A licensed owner may not register a kennel/stable name that the commission determines to be either misleading to the public or unbecoming to the sport.

6.17(8) Neither sole owners nor partners, after adopting use of a kennel/stable name, may use their real names to reflect ownership that is reflected in the kennel/stable name.

6.17(9) A fee set by the commission shall be assessed for each application for a kennel/stable name license.

6.17(10) No person may register with any racing authority a stable name which has already been registered by another person, or which is the real name of another owner of race horses, or which is the real or stable name of any prominent person who does not own race horses, or which is not plainly distinguishable from that of another registered stable name.

6.17(11) Contract kennels must be licensed with the commission, on forms furnished by the commission, in the name of the kennel booking contract entered into between the contract kennel and the facility; this name shall be listed in the official program as "kennel."

6.17(12) A licensed kennel owner shall not be a party to more than one kennel name at the same facility.

491—6.18(99D) Leases (horse racing only).

6.18(1) No licensee shall lease a racing animal for the purpose of racing at facilities in this state without prior approval of the commission representatives.

6.18(2) Both lessor and lessee must be licensed as owners.

6.18(3) Each licensee who leases a racing animal must submit a copy of that lease to the commission representatives. The lease must contain the conditions of the lease arrangement and the names of all parties and racing animals related to the lease. Failure to submit accurate and complete information under this rule is a violation of these rules.

6.18(4) Both seller and purchaser, or their agents or representatives, of a racing animal that is sold after being registered for racing with a racing association shall immediately notify the commission representatives of the sale and transfer. The commission representatives may require a declaration of the facts of the sale and transfer under oath and penalty of perjury.

491—6.19(99D) Partnerships owning racing animals.

6.19(1) A partnership is defined as a formal or informal arrangement between two or more persons to own a racing animal. All partnerships, excluding husband and wife, must be licensed with the commission on forms furnished by the commission, and in accordance with the requirements of 491—6.16(99D).

6.19(2) The managing partner(s) listed on the application and all parties owning 5 percent or more must be licensed as individual owners.

a. The commission representative may request a partnership to have on file with the commission an agreement whereby the managing partner(s) is designated to be responsible for each racing animal. This agreement must be notarized and must be signed by all partners. A copy of this agreement must be attached to the registration certificate on file in the racing secretary's office.

b. It will be the responsibility of the managing partner(s) to make sure that all parties are eligible for licensure. The commission representative shall deny, suspend, or revoke the license of any partnership in which a member (either qualified or limited by rights or interests held, or controlled by any individual or entity) would be ineligible to be licensed as an owner or to participate in racing.

c. Any owner who is a member of a partnership may be required to list all racing animals that the owner intends to race in Iowa in which an interest is owned (either in whole or in part).

d. All parties to a partnership shall be jointly and severally liable for all stakes, forfeits, and other obligations.

e. An authorized agent may be appointed to represent the partnership in all matters and be responsible for all stakes, forfeits, entries, scratches, signing of claim slips, and other obligations in lieu of the managing partner(s).

6.19(3) A partnership name under which a racing animal races shall be considered a kennel/stable name for purposes of these rules. It will not be necessary for the partnership to obtain a kennel/stable name license.

6.19(4) Any partner's share or partial share of a partnership that owns a racing animal shall not be assigned without the written consent of the other partner(s), the commission representative's approval, and filing with the racing secretary. Any alteration in a partnership structure or percentages must be reported promptly in writing, notarized, signed by all members of the partnership, and filed with the commission.

6.19(5) The commission representative may review the ownership of each racing animal entered to race and shall ensure that each registration certificate or eligibility certificate is properly endorsed by the transferor to the present owner(s). The commission representative may determine the validity for racing purposes of all liens, transfers and agreements pertaining to ownership of a racing animal and may call for adequate evidence of

ownership at any time. The commission representative may declare any animal ineligible to race if its ownership, or control of its ownership, is in question.

6.19(6) A fee set by the commission shall be assessed for each application for a partnership license.

491—6.20(99D) Corporations owning racing animals.

6.20(1) All corporations must be duly licensed by the commission on forms furnished by the commission, and in accordance with the requirements of 491—6.16(99D). In addition, any stockholder owning a beneficial interest of 5 percent or more of the corporation must be licensed as an owner. The corporation must submit a complete list of stockholders owning a beneficial interest of 5 percent or more.

6.20(2) The corporation stockholders owning less than 5 percent of the stock of a corporation need not be licensed; however, the commission may request a list of these stockholders. The list shall include names, percentages owned, addresses, social security numbers, and dates of birth. These stockholders shall not have access to the backstretch, to the paddock area, or to the winner's circle other than as guests of a facility, commission representatives, or designated licensees and may be required to submit additional information as requested by the commission representative, which may include a release for confidential information and submission of fingerprint cards; and the commission may assess costs, as required, for criminal history checks. This information shall be supplied to the commission representative within 30 days of the date of the request.

6.20(3) Any and all changes in either the corporation structure or the respective interest of stockholders as described above must be notarized and promptly filed with the commission representatives.

6.20(4) The corporate name under which the corporation does business in Iowa shall be considered a kennel/stable name for purposes of these rules. It shall not be necessary for the corporation to obtain a kennel/stable name license.

6.20(5) A corporation, in lieu of an executive officer, may appoint a racing manager or an authorized agent for the purposes of entry, scratches and the signing of claim slips, among other obligations.

6.20(6) The commission representative may deny, suspend, or revoke the license of a corporation for which a beneficial interest includes or involves any person or entity that is ineligible (through character, moral fitness or any other criteria employed by the commission) to be licensed as an owner or to participate in racing, regardless of the percentage of ownership interest involved.

6.20(7) Any stockholder holding a beneficial interest of 5 percent or more of a corporation must, in addition to being licensed, list any interest owned in all racing animals in which any beneficial interest is owned.

6.20(8) The corporation must pay a prescribed fee to the commission.

491—6.21(99D) Authorized agents for owner entities of racing animals.

6.21(1) Any persons represented by a kennel name, stable name, corporation, partnership, or single person entity may assign an agent for the kennel name, stable name, corporation, partnership, or single person entity. The assigned agent is then authorized to handle matters pertaining to racing, which may include authorization to collect all purses or other moneys.

6.21(2) The application for a license as an authorized agent must be signed by the principal and clearly set forth the powers of the agent, including whether the agent is empowered to collect money from the facility. The application must be notarized and a copy must be filed with the facility.

6.21(3) Changes in an agent's powers or revocation of an agent's authority must be in writing, notarized, and filed with the commission's licensing office and the facility.

6.21(4) The authorized agent must pay a prescribed fee to the commission.

491—6.22(99D) Trainers and assistant trainers of racing animals.

6.22(1) All trainers and assistant trainers of racing animals and their employees are subject to the laws of Iowa and the rules promulgated by the commission immediately upon acceptance and occupancy of accommodations from or approved by the facility or upon making entry to run on its track. Trainers, assistant trainers, and their employees shall accept the decision of the commission representative on any and all questions, subject to their right of appeal to the commission.

6.22(2) Licensing of trainers and assistant trainers. Eligibility:

a. An applicant must be at least 18 years of age to be licensed by the commission as a trainer or assistant trainer.

b. An applicant must be qualified, as determined by the commission representative, by reason of experience, background, and knowledge of racing. A trainer's license from another jurisdiction may be accepted as evidence of experience and qualifications. Evidence of qualifications may require passing one or more of the following:

(1) A written examination.

(2) An interview or oral examination.

(3) A demonstration of practical skills in a "barn test" (horse racing only).

c. An applicant must have a racing animal eligible to race and registered to race at the current race meeting.

491—6.23(99D) Jockeys and apprentice jockeys.

6.23(1) *Eligibility.*

a. An applicant for a jockey license must be at least 16 years of age, and if under 18 years of age, the applicant must have the written consent of a parent or guardian.

b. A jockey shall pass a physical examination given within the previous 12 months by a licensed physician affirming fitness to participate as a jockey. The commission representatives may require that any jockey be reexamined and may refuse to allow any jockey to ride pending completion of such examination.

c. An applicant shall show competence by prior licensing, demonstration of riding ability, or temporary participation in races. An applicant may participate in a race or races, with the commission representative's prior approval for each race, not to exceed five races.

d. A jockey shall not be an owner or trainer of any horse competing at the race meeting where the jockey is riding.

e. A person who has never ridden in a race at a recognized meeting shall not be granted a license as jockey or apprentice jockey.

6.23(2) *Apprentice jockeys.*

a. The conditions of an apprentice jockey license do not apply to quarter horse racing. A jockey's performance in quarter horse racing does not apply to the conditions of an apprentice jockey license.

b. An applicant with an approved apprentice certificate may be licensed as an apprentice jockey.

c. An applicant for an apprentice jockey license must be at least 16 years of age, and if under 18 years of age, the applicant must have written consent of parent or guardian. Before such license is granted, the gaming representative shall ascertain that the applicant has suitable qualifications and aptitude to hold an apprentice jockey's license and that the applicant has not been previously licensed as a jockey under any jurisdiction.

d. Rescinded IAB 1/30/08, effective 3/5/08.

6.23(3) *Jockeys from foreign countries.* Upon making application for a license in this jurisdiction, jockeys from a foreign country shall declare that they are holders of valid licenses in their countries, not under suspension, and bound by the rules and laws of this state. To facilitate this process, the jockey shall present a declaration sheet to the commission representative in a language recognized in this jurisdiction.

491—6.24(99D) Jockey agent.

6.24(1) An applicant for a license as a jockey agent shall:

a. Provide written proof of agency with at least one jockey licensed by the commission; and

b. Be qualified, as determined by the commission representative, by reason of experience, background, and knowledge. A jockey agent's license from another jurisdiction may be accepted as evidence of experience and qualifications. Evidence of qualifications may require passing one or both of the following:

(1) A written examination.

(2) An interview or oral examination.

c. An applicant not previously licensed as a jockey agent shall be required to pass a written and oral examination.

6.24(2) A jockey agent may serve as agent for no more than two jockeys and one apprentice jockey.

491—6.25(99D) Driver. In determining eligibility for a driver's license, the board shall consider:

1. Whether the applicant has obtained the required U.S.T.A. license.
2. Evidence of driving experience and ability to drive in a race.

3. The age of the applicant. No person under 18 years of age shall be licensed by the commission as a driver. However, a person under 18 years of age, but at least 16 years of age who has the written consent of a parent or guardian, may be licensed to drive in qualifying races only.

4. Evidence of physical and mental ability.

5. Results of a written examination to determine qualifications to drive and knowledge of commission rules.

6. Record of rule violations.

491—6.26(99D) Practicing veterinarians. Every veterinarian practicing on facility premises must have an unrestricted and current license to practice veterinary science issued by the state of Iowa veterinary regulatory authority and shall be licensed by the commission in accordance with the commission rules governing occupational licensing.

6.26(1) Every veterinarian seeking to be licensed by the commission shall submit verification of a current and unrestricted license to practice veterinary science issued by the state of Iowa veterinary regulatory authority.

6.26(2) A veterinarian seeking to be licensed by the commission shall disclose in the veterinarian's application to the commission all disciplinary action taken against any licenses to practice veterinary science held by the applicant.

491—6.27(99D,99F) Alcohol and drug testing.

6.27(1) *Alcohol prohibition/preliminary breath test.* Licensees whose duties require them to be in a restricted area of a racing facility shall not have present within their systems an amount of alcohol of 0.05 percent or more. A restricted area is a designated area for sample collection, paddock, racetrack, or other area where racing officials carry out the duties of their positions.

Acting with reasonable cause, a commission representative may direct the above licensees to submit to a preliminary breath test. A licensee shall, when so directed, submit to examination.

If the results show a reading of 0.05 percent alcohol content or more, the licensee shall not be permitted to continue duties for that day. For a second violation, the licensee shall not be permitted to continue duties for that day and then shall be subject to fine or suspension by the board or commission representative. For a subsequent violation the licensee may be subject to procedures following positive chemical analysis (see 6.27(3)).

If the results show a reading of 0.10 percent alcohol content or more, the licensee is subject to fine or suspension by the board or commission representative. For a subsequent violation the licensee may be subject to procedures following positive chemical analysis (see 6.27(3)).

6.27(2) *Drug prohibition/body fluid test.* Licensees whose duties require them to be in a restricted area, as defined in subrule 6.27(1), of a racing facility shall not have present within their systems any controlled substance as listed in Schedules I to V of U.S.C. Title 21 (Food and Drug Section 812), Iowa Code chapter 124 or any prescription drug unless it was obtained directly or pursuant to valid prescription or order from a duly licensed physician who is acting in the course of professional practice. Acting with reasonable cause, a commission representative may direct the above licensees to deliver a specimen of urine or subject themselves to the taking of a blood sample or other body fluids at a collection site approved by the commission. In these cases, the commission representative may prohibit the licensee from participating in racing until the licensee evidences a negative test result. Sufficient sample should be collected to ensure a quantity for a split sample when possible. A licensee who refuses to provide the samples herein described shall be in violation of these rules and shall be immediately suspended and subject to disciplinary action by the board or commission representative. All confirmed positive test costs and any related expenses shall be paid for by the licensee. Negative tests shall be at the expense of the commission.

With reasonable cause noted, an on-duty commission representative may direct a licensee to deliver a test. The commission representative shall call the approved laboratory or hospital and provide information regarding the person who will be coming; that the licensee will have a photo ID; the name and number to call when the licensee arrives; to whom and where to mail the results; and who should be called with the results. The licensee will be directed to immediately leave the work area and proceed to an approved laboratory or hospital for testing with the following directions:

1. If under impairment, the licensee must have another person drive the licensee to the laboratory or hospital.

2. On arrival at the laboratory or hospital, the licensee must show the license to the admitting personnel for verification.

3. On arrival at the laboratory or hospital, the licensee shall be required to sign a consent for the release of information of the results to a commission representative.

6.27(3) *Procedures following positive chemical analysis.*

a. After professional evaluation, if the licensee's condition proves nonaddictive and not detrimental to the best interest of racing, and the licensee can produce a negative test result and agrees to further testing at the discretion of the commission representative to ensure unimpairment, the licensee may be allowed to participate in racing.

b. After professional evaluation, should the licensee's condition prove addictive or detrimental to the best interest of racing, the licensee shall not be allowed to participate in racing until the licensee can produce a negative test result and show documented proof of successful completion of a certified alcohol/drug rehabilitation program approved by the commission. The licensee must also agree to further testing at the discretion of the commission representative to ensure unimpairment.

c. For a second violation, a licensee shall be suspended and allowed to enroll in a certified alcohol/drug rehabilitation program approved by the administrator and to apply for reinstatement only at the discretion of the administrator.

These rules are intended to implement Iowa Code chapters 99D and 99F.

[Filed 8/18/00, Notice 7/12/00—published 9/6/00, effective 10/11/00]
[Filed 4/24/01, Notice 2/7/01—published 5/16/01, effective 6/20/01]
[Filed 8/22/01, Notice 6/27/01—published 9/19/01, effective 10/24/01]
[Filed 9/20/01, Notice 8/8/01—published 10/17/01, effective 11/21/01]
[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]
[Filed 6/6/03, Notice 4/2/03—published 6/25/03, effective 7/30/03]
[Filed 4/21/04, Notice 2/4/04—published 5/12/04, effective 6/16/04]
[Filed 9/7/04, Notice 7/7/04—published 9/29/04, effective 11/3/04]
[Filed 4/21/05, Notice 2/16/05—published 5/11/05, effective 6/15/05]
[Filed 4/20/07, Notice 2/14/07—published 5/9/07, effective 6/13/07]
[Filed 1/11/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
[Filed 6/6/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]

CHAPTER 9
HARNESS RACING

[Prior to 11/9/86, Racing Commission[693]]
[Prior to 11/18/87, Racing and Gaming Division[195]]

491—9.1(99D) Terms defined. As used in these rules, unless the context otherwise requires, the following definitions apply:

"Also eligible" means a number of eligible horses, properly entered, which were not drawn for inclusion in a race, but which become eligible according to preference or lot if an entry is scratched prior to the scratch time deadline; or the next preferred nonqualifier for the finals or consolation from a set of elimination trials, which will become eligible in the event a finalist is scratched by the stewards for a rule violation; or is otherwise eligible if written race conditions permit.

"Arrears" means all moneys owed by a licensee, including subscriptions, forfeitures, and any other payment and default incident to these rules.

"Authorized agent" means a person licensed by the commission as an agent for a horse owner or principal by virtue of a notarized appointment. The agent shall be designated on a form approved by the commission and filed by the owner or principal with the commission authorizing the agent to handle matters pertaining to racing and stabling, including authorization to claim and to withdraw money from the horsemen's bookkeeper.

"Bleeder" means a horse that hemorrhages from within the respiratory tract during a race or within one and one-half hours postrace, during exercise or within one and one-half hours of exercise.

"Bleeder list" means a tabulation of all bleeders to be maintained by the commission.

"Chemist" means any official racing chemist designated by the commission.

"Claiming race" means a race which includes a condition that any horse starting the race may be claimed and purchased by any licensed owner, or person(s) approved by the commission for an owner's license, for the designated amount specified in the conditions for that race by the racing secretary.

"Commission" means the Iowa racing and gaming commission.

"Conditioned race" means any overnight event to which eligibility is determined according to specified qualifications.

"Conditions" means qualifications that determine a horse's eligibility to be entered in a race.

"Contest" means a competitive racing event on which pari-mutuel wagering is conducted.

"Contestant" means an individual participant in a contest.

"Coupled entry" means two or more contestants in a contest that are treated as a single betting interest for pari-mutuel wagering purposes. (See also "Entry.")

"C.T.A." means Canadian Trotting Association.

"Dash" means a race decided in a single trial. Dashes may be given in a series of two or three governed by one entry fee for the series, in which event a horse must start in all dashes. Positions may be drawn for each dash. The number of premiums awarded shall not exceed the number of starters in the dash.

"Day" means a 24-hour period ending at midnight.

"Declaration" means the naming of a particular horse into a particular race.

"Detention barn" means the barn designated for the collection from horses of test samples under the supervision of the commission veterinarian; also, the barn assigned by the commission to a horse on the bleeder list for occupancy as a prerequisite for receiving bleeder medication.

"Driver" means a person licensed to drive in races as a driver.

"Early closing race" means a race for a definite amount, to which entries close at least six weeks preceding the race. The entrance fee may be on the installment plan and no payment shall be refunded.

"Elimination heats" means the individual heats of a race in which the contestants must qualify for a final heat.

"Entry" means a horse made eligible to run in a race; or two or more horses, entered in the same race, which have common ties of ownership, lease, or training. (See also "Coupled entry.")

"Facility" means an entity licensed by the commission to conduct pari-mutuel wagering or gaming operations in Iowa.

"Facility premises" means all real property utilized by the facility in the conduct of its race meeting, including the racetrack, grandstand, concession stands, offices, barns, stables area, employee housing facilities, parking lots, and any other areas under the jurisdiction of the commission.

"Foreign substances" means all substances except those that exist naturally in the untreated horse at normal physiological concentration.

"Futurity" means a stake in which the dam of the competing animal is nominated either when in foal or during the year of foaling.

"Handicap" means a race in which allowance for performance, sex, or distance is made. Post positions for a handicap may be assigned by the racing secretary. Post positions in a handicap claiming race may be determined by claiming price.

"Heat" means a single trial in a race, two in three, or three heat plan.

"Horse" means any equine, including equine designated as a mare, filly, stallion, colt, ridgling or gelding, registered for racing.

"Late closing race" means a race for a fixed amount to which entries close less than six weeks and more than three days before the race is to be contested.

"Licensee" means any person or entity licensed by the commission to engage in racing or related regulated activity.

"Matinee race" means a race in which an entrance fee may be charged and the premiums, if any, are other than money.

"Meeting" means the specified period and dates each year during which a facility is authorized by the commission to conduct pari-mutuel wagering.

"Month" means a calendar month.

"Nomination" means the naming of a horse or, in the event of a futurity, the naming of a foal in utero to a certain race or series of races, when eligibility is conditioned on the payment of a fee at the time of naming and the payment of subsequent sustaining fees or starting fees.

"Nominator" means the person or entity in whose name a horse is nominated for a race or series of races.

"Objection" means a verbal claim of foul in a race lodged by the horse's driver, trainer, owner, or the owner's authorized agent before the race is declared official.

"Optional claiming race" means a contest restricted to horses entered to be claimed for a stated claiming price or to those horses eligible to a specified condition in the case of horses to be claimed in such a race. The race shall be considered, for the purpose of these rules, a claiming race; in the case of horses not entered to be claimed in such a race, the race shall be considered a condition race.

"Overnight race" means a race for which declarations close not more than three days (omitting Sundays) or less than one day before such race is to be contested. In the absence of conditions or notice to the contrary, all entries in overnight events must close not later than 12 noon the day preceding the race.

"Owner" means a person or entity that holds any title, right, or interest, whole or partial, in a horse, including the lessee and lessor of a horse.

"Paddock" means an enclosure in which horses scheduled to compete in a contest are confined prior to racing.

"Post position" means the position behind the starting gate assigned to, drawn by, or earned by a horse.

"Post time" means the scheduled starting time for a contest.

"Race" means a contest between horses for a purse, prize, or other reward contested at a facility in the presence of the stewards of the meeting. Every heat or dash shall be deemed a race for pari-mutuel betting purposes.

"Restricted area" means an area of the facility premises to which access is limited including, but not limited to, a designated area for sample collection, paddock, racetrack, or other area where racing officials carry out the duties of their positions.

"Rules" means the rules promulgated by the commission or U.S.T.A. to regulate the conduct of harness racing. Where a conflict exists between the commission and the U.S.T.A. rules, the commission's rule shall govern.

"Scratch" means the act of withdrawing an entered horse from a contest after the closing of entries.

"Scratch time" means the deadline set by the facility for withdrawal of entries from a scheduled performance.

"Stable name" means a name used, other than the actual legal name of an owner or lessee, and registered with the U.S.T.A. and the commission.

"Stake" means a race that will be contested in a year subsequent to its closing, for which the money given to the facility conducting the same is added to the money contributed by the nominators, all of which, except deductions for the cost of promotion and breeders of nominators awards, belongs to the winner or winners.

"Starter" means a horse that becomes an actual contestant when the word "go" is given by the official starter.

"Steward" means a duly appointed racing official with powers and duties specified by commission rules.

"Subscription" means moneys paid for nomination, entry, eligibility, or starting of a horse in a stakes race.

"U.S.T.A." means the United States Trotting Association.

"Veterinarian" means a veterinarian holding a current unrestricted license issued by the state of Iowa regulatory authority and licensed by the commission.

"Year" means a calendar year.

491—9.2(99D) Facilities' responsibilities.

9.2(1) *Stalls.* The facility shall ensure that racing animals are stabled in individual box stalls; that the stables and immediate surrounding area are maintained in approved sanitary condition at all times; that satisfactory drainage is provided; and that manure and other refuse are kept in separate boxes or containers at locations distant from living quarters and promptly and properly removed.

9.2(2) *Paddocks and equipment.* The facility shall ensure that paddocks, starting gates, and other equipment subject to contact by different animals are kept in a clean condition and free of dangerous surfaces.

9.2(3) *Receiving barn and stalls.* Each facility shall provide a conveniently located receiving barn or stalls for the use of horses arriving during the meeting. The barn shall have adequate stable room and facilities, hot and cold water, and stall bedding. The facility shall employ attendants to operate and maintain the receiving barn or stalls in a clean and healthy condition.

9.2(4) *Fire protection.* The facility shall develop and implement a program for fire prevention on facility premises in accordance with applicable state fire codes. The facility shall instruct employees working on facility premises of procedures for fire prevention and evacuation. The facility shall, in accordance with state fire codes, prohibit the following:

a. Smoking in horse stalls, feed and tack rooms, and in the alleyways.

b. Sleeping in feed rooms or stalls.

c. Open fires, oil- or gasoline-burning lanterns, or lamps in the stable area.

d. Leaving any electrical appliance unattended or in unsafe proximity to walls, beds, or furnishings.

e. Keeping flammable materials, including cleaning fluids or solvents, in the stable area.

f. Locking a stall which is occupied by a horse.

The facility shall post a notice in the stable area which lists the prohibitions outlined in 9.2(4)*"a"* to *"f"* above.

9.2(5) *Starting gate.* During racing hours a facility shall provide at least two operable starting gates that have been approved by the commission.

9.2(6) *Distance markers.*

a. A facility shall provide and maintain starting point markers and distance poles in a size and position that can be clearly seen from the stewards' stand.

b. The starting point markers and distance poles must be marked as follows:

1/4 poles	red and white horizontal stripes
1/8 poles	green and white horizontal stripes
1/16 poles	black and white horizontal stripes

9.2(7) *Detention barn.* Each facility shall maintain a detention barn for use by the commission for securing samples of urine, saliva, blood, or other bodily substances or tissues for chemical analysis from horses who have run in a race. The enclosure shall include a wash rack, commission veterinarian office, a walking ring, at least four stalls, workroom for the sample collectors with hot and cold running water, and glass observation windows for viewing of the horses from the office and workroom. An owner, trainer, or designated representative licensed by the commission shall be with a horse in the detention barn at all times.

9.2(8) *Ambulance.* A facility shall maintain, on the premises during every day that its track is open for racing or exercising, an ambulance for humans and an ambulance for horses, equipped according to prevailing standards and staffed by medical doctors, paramedics, or other personnel trained to operate them. When an ambulance is used for transfer of a horse or patient to medical facilities, a replacement ambulance must be furnished by the facility to comply with this rule.

9.2(9) *Helmets.* A facility shall not allow any person to drive any horse on facility premises unless that person is wearing a protective helmet, of a type approved by the commission, securely fastened under the chin.

9.2(10) *Racetrack.*

a. The surface of a racetrack, including cushion, subsurface, and base, must be designed, constructed, and maintained to provide for the safety of the drivers and racing animals.

b. Distances to be run shall be measured from the starting line at a distance three feet out from the inside rail.

c. A facility shall provide an adequate drainage system for the racetrack.

d. A facility shall provide adequate equipment and personnel to maintain the track surface in a safe training and racing condition. The facility shall provide backup equipment for maintaining the track surface.

e. Rails.

(1) Racetracks shall have inside and outside rails, including gap rails, designed, constructed, and maintained to provide for the safety of drivers and horses. The design and construction of rails must be approved by the commission prior to the first race meeting at the track.

(2) All rails must be constructed of materials designed to withstand the impact of a horse.

9.2(11) *Blacksmith.* During racing hours, each facility shall provide the services of a blacksmith within the paddock.

9.2(12) *Extra equipment.* During racing hours, each facility shall provide suitable extra equipment as may be necessary for the conduct of racing without unnecessary delay.

9.2(13) *Head numbers and saddle pads.* Head numbers and saddle pads must be used on horses when warming up and racing. The saddle pads in use at the facility conducting extended pari-mutuel meetings shall be standardized consistent with a format to be established by U.S.T.A.

9.2(14) *Supervision of meeting.* Although facilities have the obligation of general supervision of their meeting, interference with the proper performance of duties of any official is prohibited.

9.2(15) *Patrol films or video recordings.* Each facility shall provide:

a. A video recording system approved by the commission. Cameras must be located to provide clear panoramic and head-on views of each race. Separate monitors, which simultaneously display the images received from each camera and are capable of simultaneously displaying a synchronized view of the recordings of each race for review, shall be provided in the stewards' stand. The location and construction of video towers must be approved by the commission.

b. One camera, designated by the commission, to record the prerace of all horses approaching the starting gate and to continue to record until the field is dispatched by the starter.

c. One camera, designated by the commission, to record the apparent winner of each race from the finish line until the horse has returned and the driver has dismounted.

d. At the discretion of the stewards, video camera operators to record the activities of any horses or persons handling horses prior to, during, or following a race.

e. At least three video cameras to record races run on an oval track.

f. Upon request of the commission, without cost, a copy of a video recording of a race.

g. That video recordings recorded prior to, during, and following each race be maintained by the facility for not less than six months after the end of the race meeting, or such other period as may be requested by the stewards or the commission.

h. A viewing room in which, on approval by the stewards, an owner, trainer, driver, or other interested individual may view a video recording of a race.

i. Following any race in which there is an inquiry or objection, the video recorded replays of the incident in question which were utilized by the stewards in making their decision. The facility shall display to the public these video recorded replays on designated monitors.

9.2(16) *Communications.*

a. Each facility shall provide and maintain in good working order a communication system between the:

(1) Stewards' stand;

(2) Racing office;

(3) Tote room;

(4) Drivers' room;

(5) Paddock;

(6) Detention barn;

(7) Starting gate;

(8) Video camera locations;

(9) Clocker's stand;

(10) State racing veterinarian;

(11) Track announcer;

(12) Location of the ambulances (equine and human); and

(13) Other locations and persons designated by the commission.

b. A facility shall provide and maintain a public address system capable of clearly transmitting announcements to the patrons and to the stable area.

9.2(17) *Horsemen's bookkeeper.*

a. General authority. The horsemen's bookkeeper shall maintain the records and accounts and perform the duties described herein and maintain such other records and accounts and perform such other duties as the facility and commission may prescribe.

b. Records.

(1) The records shall include the name, mailing address, social security number or federal tax identification number, and the state or country of residence of each horse owner, trainer, or driver participating at the race meeting who has funds due or on deposit in the horsemen's account.

(2) The records shall include a file of all required statements of partnerships, syndicates, corporations, assignments of interest, lease agreements, and registrations of authorized agents.

(3) All records of the horsemen's bookkeeper shall be kept separate and apart from the records of the facility.

(4) All records of the horsemen's bookkeeper, including records of accounts and moneys and funds kept on deposit, are subject to inspection by the commission at any time.

c. Moneys and funds on account.

(1) All moneys and funds on account with the horsemen's bookkeeper shall be maintained:

1. Separate and apart from moneys and funds of the facility;

2. In a trust account designated as "horsemen's trust account"; and

3. In an account insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

(2) The horsemen's bookkeeper shall be bonded.

d. Payment of purses.

(1) The horsemen's bookkeeper shall receive, maintain, and disburse the purse of each race and all stakes, entrance money, driver fees, purchase money in claiming races, all applicable taxes, and other moneys that properly come into the horsemen's bookkeeper's possession in accordance with the provisions of commission rules.

(2) The horsemen's bookkeeper may accept moneys due, belonging to other organizations or recognized meetings, provided prompt return is made to the organization to which the money is due.

(3) The horsemen's bookkeeper shall disburse the purse of each race and all stakes, entrance money, driver fees, purchase money in claiming races, and all applicable taxes, upon request, within 48 hours of receipt of notification that all tests with respect to such races have cleared the drug testing laboratory (commission chemist) as reported by the stewards.

(4) Absent a prior request, the horsemen's bookkeeper shall disburse moneys to the persons entitled to receive same within 15 days after the last race day of the race meeting, including purses for official races, provided that all tests with respect to such races have cleared the drug testing laboratory as reported by the stewards, and provided further that no protest or appeal has been filed with the stewards or the commission.

(5) In the event a protest or appeal has been filed with the stewards or the commission, the horsemen's bookkeeper shall disburse the purse within 48 hours of receipt of dismissal or a final nonappealable order disposing of such protest or appeal.

e. No portion of purse money other than driver fees shall be deducted by the facility for itself or for another, unless so requested in writing by the person to whom purse moneys are payable or the person's duly authorized representative. The horsemen's bookkeeper shall mail to each owner a duplicate of each record of all deposits, withdrawals, or transfers of funds affecting the owner's racing account at the close of each race meeting.

9.2(18) *Timer.* Each facility shall provide for each race an official timer who shall occupy the timer's stand or other appropriate place to observe the contesting of each race. The official timer shall accurately record the time elapsed between the start and finish of each race. The chief timer shall sign the stewards' book for each race verifying the correctness of the record.

491—9.3(99D) Facility policies. It shall be the affirmative responsibility and continuing duty of each occupational licensee to follow and comply with the facility policies as published and distributed by the facility or posted in a conspicuous location.

491—9.4(99D) Racing officials.

9.4(1) *General description.* Every facility conducting a race meeting shall appoint at least the following officials, who shall all have U.S.T.A. certification:

a. One of the members of a three-member board of stewards;
b. Racing secretary;
c. Paddock judge;
d. Horse identifier;
e. Clerk of the course;
f. Official starter;
g. Official charter;
h. Program director;
i. Placing judge;
j. Any other person designated by the commission.

9.4(2) *Officials' prohibited activities.* No racing official or racing official's assistant(s), while serving in that capacity during any meeting, may engage in any of the following:

a. Enter into a business or employment that would be a conflict of interest, interfere with, or conflict with the proper discharge of duties, including a business that does business with a facility or a business issued a concession operator's license;

b. Participate in the sale, purchase, or ownership of any horse racing at the meeting;

c. Sell or solicit horse insurance on any horse racing at the meeting, or any other business sales or solicitation not a part of the official's duties;

d. Wager on the outcome of any race under the jurisdiction of the commission;

e. Accept or receive money or anything of value for the official's assistance in connection with the official's duties;

f. Consume or be under the influence of alcohol or any prohibited substance while performing official duties.

9.4(3) *Single official appointment.* No official appointed to any meeting may hold more than one official position listed in 9.4(1) unless, in the determination of the stewards or commission, the holding of more than one appointment would not subject the official to a conflict of interest or duties in the two appointments.

9.4(4) *Stewards.* (For practice and procedure before the stewards and the commission, see 491—Chapter 4.)

a. General authority.

(1) General. The stewards for each race meeting shall be responsible to the commission for the conduct of the race meeting in accordance with the laws of this state and the rules adopted by the commission. The stewards shall have authority to regulate and to resolve conflicts or disputes between all other racing officials, licensees, and those persons addressed by 491—paragraph 4.6(5)*"e"* which are reasonably related to the conduct of a race or races and to discipline violators of these rules in accordance with the provisions of these rules.

(2) Period of authority. The stewards' authority as set forth in this subrule shall commence 30 days prior to the beginning of each race meeting and shall terminate 30 days after the end of each race meeting or with the completion of their business pertaining to the meeting.

(3) Attendance. All three stewards shall be present in the stand during the running of each race.

(4) Appointment of substitute. Should any steward be absent at race time, the state steward(s) shall appoint a deputy for the absent steward. If any deputy steward is appointed, the commission shall be notified immediately by the stewards.

(5) Initiate action. The stewards shall take notice of questionable conduct or rule violations, with or without complaint, and shall initiate investigations promptly and render a decision on every objection and every complaint made to them.

(6) General enforcement provisions. Stewards shall enforce the laws of Iowa and the rules of the commission. The laws of Iowa and the rules of the commission apply equally during periods of racing. The laws and rules supersede the conditions of a race and the regulations of a race meeting and, in matters pertaining to racing, the orders of the stewards supersede the orders of the officers of the facility. The decision of the stewards

as to the extent of a disqualification of any horse in any race shall be final for purposes of distribution of the pari-mutuel pool.

b. Other powers and authority.

(1) The stewards shall have the power to interpret the rules and to decide all questions not specifically covered by the rules.

(2) All questions within the stewards' authority shall be determined by a majority of the stewards.

(3) The stewards shall have control over and access to all areas of the facility premises.

(4) The stewards shall have the authority to determine all questions arising with reference to entries and racing. Persons entering horses to run at a facility agree in so doing to accept the decision of the stewards on any questions relating to a race or racing. The stewards, in their sole discretion, are authorized to determine whether two or more individuals or entities are operating as a single financial interest or as separate financial interests. In making this determination, the stewards shall consider all relevant information including, but not limited to, the following:

1. Whether the parties pay bills from and deposit receipts in the same accounts.

2. Whether the parties share resources such as employees, feed, supplies, veterinary and farrier services, tack, and equipment.

3. Whether the parties switch horses or owner/trainer for no apparent reason, other than to avoid restrictions of being treated as a single interest.

4. Whether the parties engage in separate racing operations in other jurisdictions.

5. Whether the parties have claimed horses, or transferred claimed horses after the fact, for the other's benefit.

6. If owners, whether one owner is paying the expenses for horses not in the owner's name as owner.

7. If trainers, whether the relationship between the parties is more consistent with that of a trainer and assistant trainer.

(5) The stewards shall have the authority to discipline, for violation of the rules, any person subject to their control and, in their discretion, to impose fines or suspensions, or both, for infractions.

(6) The stewards shall have the authority to order the exclusion or ejection from all premises and enclosures of the facility any person who is disqualified for corrupt practices on any race course in any country.

(7) The stewards shall have the authority to call for proof that a horse is itself not disqualified in any respect, or nominated by, or wholly or in part the property of a disqualified person. In default of proof being given to their satisfaction, the stewards may declare the horse disqualified.

(8) The stewards shall have the authority at any time to order an examination of any horse entered for a race or which has run in a race.

(9) In order to maintain necessary safety and health conditions and to protect the public confidence in horse racing as a sport, the stewards have the authority to authorize a person(s) on their behalf to enter into or upon the buildings, barns, motor vehicles, trailers, or other places within the premises of a facility, to examine same, and to inspect and examine the person, personal property, and effects of any person within such place, and to seize any illegal articles or any items as evidence found.

(10) The stewards shall maintain a log of all infractions of the rules and of all rulings of the stewards upon matters coming before them during the race meet.

(11) The state stewards must give prior approval for any person other than the commissioners or commission representative to be allowed in the stewards' stand.

(12) The stewards shall determine the winner of each race and the order of finish for each of the remaining horses in the race. In case of a difference of opinion among the stewards, the majority opinion shall govern. In determining places at the finish of a race, the stewards shall consider only the noses of the placing horses. The stewards' decision on the race shall be final.

(13) The stewards may correct errors in their determination of the placing of horses at the finish before the display of the official sign or, if the official sign has been displayed in error, after that display. If the display is in error, no person shall be entitled to any proceeds of the pari-mutuel pool on account of the error.

c. Emergency authority.

(1) Substitute officials. When, in an emergency, any official is unable to discharge the official's duties, the stewards may approve the appointment of a substitute and shall report it immediately to the commission.

(2) Substitute driver. The stewards have the authority, in an emergency, to designate a substitute driver for any horse. Before using that authority, the stewards shall in good faith attempt to inform the trainer of the

emergency and to afford the trainer the opportunity to appoint a substitute driver. If the trainer cannot be contacted, or if the trainer is contacted but fails to appoint a substitute driver and inform the stewards of the substitution by 30 minutes prior to post time, then the stewards may appoint a substitute driver under this rule.

(3) Substitute trainer. The stewards have the authority in an emergency to designate a substitute trainer for any horse.

(4) Excuse horse. In case of accident or injury to a horse or any other emergency deemed by the stewards before the start of any race, the stewards may excuse the horse from starting.

(5) Exercise authority. No licensee may exercise a horse on the track between races unless upon the approval of the stewards.

(6) Nonstarter. At the discretion of the stewards, any horse(s) precluded from having a fair start may be declared a nonstarter, and any wagers involving said horse(s) may be ordered refunded.

d. Investigations and decisions.

(1) Investigations. The stewards may, upon direction of the commission, conduct inquiries and shall recommend to the commission the issuance of subpoenas to compel the attendance of witnesses and the production of reports, books, papers, and documents for any inquiry. The commission stewards have the power to administer oaths and examine witnesses. The stewards shall submit a written report to the commission of every such inquiry made by them.

(2) Form reversal. The stewards shall take notice of any marked reversal of form by any horse and shall conduct an inquiry of the horse's owner, trainer, or other persons connected with the horse including any person found to have contributed to the deliberate restraint or impediment of a horse in order to cause it not to win or finish as near as possible to first.

(3) Fouls.

1. Extent of disqualification. Upon any claim of foul submitted to them, the stewards shall determine the extent of any disqualification and place any horse found to be disqualified behind others in the race with which it interfered or may place the offending horse last in the race. The stewards, at their discretion, may determine if there was sufficient interference or intimidation to affect the outcome of the race and take the appropriate actions thereafter.

2. Coupled entry. When a horse is disqualified under 9.4(4)*"d"*(3)"1" and that horse was a part of a coupled entry and, in the opinion of the stewards, the act which led to the disqualification served to unduly benefit the other part of the coupled entry, the stewards may disqualify the other part of the entry.

3. Driver guilty of foul. The stewards may discipline any driver whose horse has been disqualified as a result of a foul committed during the running of a race.

(4) Protests and complaints. The stewards shall investigate promptly and render a decision in every protest and complaint made to them. They shall keep a record of all protests and complaints and any rulings made by the stewards and shall file reports daily with the commission.

1. Involving fraud. Protests involving fraud may be made by any person at any time. The protest must be made to the stewards.

2. Not involving fraud. Protests, except those involving fraud, may be filed only by the owner of a horse, authorized agent, trainer, or the driver of the horse in the race about which the protest is made. The protest must be made to the stewards before the race is declared official.

3. Prize money of protested horse. During the time of determination of a protest, any money or prize won by a horse protested or otherwise affected by the outcome of the race shall be paid to and held by the horsemen's bookkeeper until the protest is decided.

4. Protest in writing. A protest, other than one arising out of the actual running of a race, must be in writing, signed by the complainant, and filed with the stewards not later than one hour before post time of the race out of which the protest arises.

5. Frivolous protests. No person shall make a frivolous protest nor may any person withdraw a protest without the permission of the stewards.

9.4(5) *Racing secretary.*

a. General authority. The racing secretary is responsible for setting the conditions for each race of the meeting, regulating the nomination of entries, determining the amounts of purses and to whom they are due, and the recording of racing results. The racing secretary shall permit no person other than licensed racing officials to enter the racing secretary's office or work areas until such time as all entries are closed, drawn, and smoked. Exceptions to this rule must be approved by the stewards.

b. Conditions. The racing secretary shall establish the conditions and eligibility for entering the races of the meeting and cause them to be published to owners, trainers, and the commission. Corrections to the conditions must be made within 24 hours of publication.

c. Posting of entries. Upon the completion of the draw each day, the racing secretary shall post a list of entries in a conspicuous location in the racing office and make the list available to the public.

d. Stakes and entrance money records. The racing secretary shall be caretaker of the permanent records of all stakes, entrance moneys, and arrears paid or due in a race meeting and shall keep permanent records of the results of each race of the meeting.

e. Winnings—all inclusive. For the purpose of the setting of conditions by the racing secretary, winnings shall be considered to include all moneys and bonus awards won up to the time when entries close, but winnings on the closing date of eligibility shall not be considered.

f. Cancellation of a race. The racing secretary has the authority to withdraw, cancel, or change any race which has not been closed. In the event the canceled race is a stakes race, all subscriptions and fees paid in connection with the race shall be refunded.

g. Coggins test or equine infectious anemia. The racing secretary shall ensure that all horses have a current negative Coggins test or negative equine infectious anemia test. The racing secretary shall report all expired certificates to the stewards.

h. Rejection of declaration.

(1) The racing secretary may reject the declaration of any horse whose eligibility certificate or electronic eligibility certificate was not in the possession of the racing secretary on the date the condition book was published.

(2) The racing secretary may reject the declaration of any horse whose past performance indicates that the horse would be below the competitive level of other horses declared, provided the rejection does not result in a race's being canceled.

i. Eligibility certificate or electronic eligibility certificates. The racing secretary will receive and keep the eligibility certificate or electronic eligibility certificate of horses competing at the facility and return same to the owner or the owner's representative upon request.

j. Declaration blanks. The racing secretary will examine all declaration blanks to verify all information set forth therein.

k. Verification of eligibility. The racing secretary will check the eligibility of all horses drawn in to race and verify the horses' eligibility with the stewards.

l. Registration. The racing secretary shall be responsible for the care and security of all registrations and supporting documents submitted by the trainers while the horses are located on facility premises. Disclosure is made for the benefit of the public, and all documents pertaining to the ownership or lease of a horse filed with the racing secretary shall be available for public inspection.

m. Certificates. Rescinded IAB 10/17/01, effective 11/21/01.

9.4(6) *Paddock judge.*

a. General authority. The paddock judge shall:

(1) Be in charge of the paddock and shall have general responsibility for the inspection of horses and for the equipment used.

(2) Attempt to maintain consistency in the use of equipment on individual horses.

(3) Supervise paddock gate men.

b. Duties. The paddock judge shall:

(1) Ensure that only properly authorized persons are permitted in the paddock.

(2) Get the fields on the racetrack for post parades.

(3) Properly check in and check out horses and drivers.

(4) Immediately notify the stewards of anything that could in any way change, delay, or otherwise affect the racing program.

(5) Report to stewards any observed cruelty to a horse.

9.4(7) *Horse identifier.*

a. General authority. The horse identifier shall be present for each race. The identifier shall inspect the horse's tattoo number or freeze brand number, color, and any markings prior to the horse's departure from the paddock to post to ensure it is the appropriate horse.

b. *Report violations.* Any discrepancy detected in the tattoo number or freeze brand number, color or markings of a horse shall be reported immediately to the paddock judge, who shall in turn report same forthwith to the stewards.

9.4(8) *Clerk of the course.* The clerk of the course shall be responsible for keeping and verifying the stewards' book, eligibility certificates or electronic eligibility certificates provided by the U.S.T.A. or C.T.A. and shall:

a. Record therein the following information:

(1) Names and addresses of owners;

(2) The standard symbols for medications, where applicable;

(3) Notations of placing, disqualifications, and claimed horses; and

(4) Notations of scratched or ruled out horses.

b. Rescinded IAB 5/10/06, effective 6/14/06.

c. Notify owners and drivers of penalties assessed by the official.

d. Assist in drawing post positions, if requested.

e. Maintain the stewards' list.

9.4(9) *Starter.*

a. *General authority.* The starter is responsible for providing a fair start for each race.

b. *Disciplinary action.* The official starter may recommend to the stewards fines or suspension of the licenses of drivers for any violations of these rules from the formation of the parade until the word "go" is given.

c. *Starter's list.* The official starter shall school horses as may be necessary and shall prepare a list of horses not qualified to start, which shall be delivered to the stewards and the racing secretary and entered on the starter's list. The starter's list shall be posted in the racing secretary's office. No horse on the starter's list shall be eligible to declare until removed from the list.

9.4(10) *Official charter.* The charting of races is mandatory and the facility shall employ a licensed charter from the U.S.T.A.

9.4(11) *Commission veterinarians (veterinarian).*

a. The veterinarian(s) shall advise the commission and the stewards on all veterinary matters.

b. The veterinarian(s) shall have supervision and control of the detention barn for the collection of test samples for the testing of horses for prohibited medication as provided in Iowa Code sections 99D.23(2) and 99D.25(9). The commission may employ persons to assist the veterinarian(s) in maintaining the detention barn area and collecting test samples.

c. The veterinarian(s) shall not buy or sell any horse under the veterinarian's supervision; wager on a race under the veterinarian's supervision; or be licensed to participate in racing in any other capacity.

d. The veterinarian(s) may request that any horse entered in a race undergo an examination on the day of the race to determine the general fitness of the horse for racing. During the examination, all bandages shall be removed by the groom upon request and the horse may be exercised outside the stall to permit the examiner to determine the condition of the horse's legs and feet. The examining veterinarian shall report any unsoundness in a horse to the stewards.

e. A veterinarian shall inspect all of the horses in a race in the paddock, during the post parade and scoring prior to the start, and shall observe the horses upon their leaving the track after the finish of a race.

f. The veterinarian shall place any horse determined to be sick or too unsafe, unsound, or unfit to race on a veterinarian's list that shall be posted in a conspicuous place available to all owners, trainers, and officials.

g. A horse placed on the veterinarian's list, bleeders exempt, may be allowed to enter only after it has been removed from the list by the commission veterinarian. Requests for the removal of any horse from the veterinarian's list will be accepted only after three calendar days have elapsed from the placing of the horse on the veterinarian's list. Removal from the list will be at the discretion of the commission veterinarian who may require satisfactory workouts or examinations to adequately demonstrate that the problem that caused the horse to be placed on the list has been rectified. Horses that are entered to race and then placed on the veterinarian's list for any reason will not be allowed to enter a race for a minimum of three calendar days beginning the day after the horse was scheduled to race.

Every confirmed bleeder, regardless of age, shall be placed on the bleeder list and shall be ineligible to race for the following time periods:

(1) First incident – 14 days.

(2) Second incident within 365-day period – 30 days.

(3) Third incident within 365-day period – 180 days.

(4) Fourth incident within 365-day period – barred for racing lifetime.

For the purposes of counting the number of days a horse is ineligible to run, the day the horse bled externally is the first day of the recovery period. The voluntary administration of furosemide without an external bleeding incident shall not subject the horse to the initial period of ineligibility specified in subparagraph (1). A horse may be removed from the bleeder list only upon the direction of the official veterinarian who shall certify in writing to the stewards the recommendation for removal. A horse which has been placed on a bleeder list in another jurisdiction pursuant to these rules shall be placed on a bleeder list in this jurisdiction.

h. The veterinarian(s) shall supervise and ensure that the administration of furosemide and phenylbutazone is in compliance with Iowa Code section 99D.25A.

i. Rescinded IAB 9/29/04, effective 11/3/04.

j. The veterinarian(s) or commission representative shall take receipt of veterinary reports as required by Iowa Code section 99D.25(10).

9.4(12) *Driver room custodian.* The driver room custodian shall have the following duties:

a. Maintain order, decorum and cleanliness in the driver's room.

b. Ensure that no person other than representatives of the commission, representatives of the facility, and drivers are admitted to the driver's room on a racing day except by permission of the stewards and ensure that no unauthorized personnel are permitted in the driver's room after the final race on racing days.

c. Ensure that drivers are neat in appearance and properly attired when they leave the driver's room to drive in a race.

d. Report any rule violations within the driver's room to stewards.

e. Assign to each driver a locker for the use of the driver in storing clothing, equipment and personal effects.

9.4(13) *Mutuel manager.* The mutuel manager is responsible for the operation of the mutuel department. The mutuel manager shall ensure that any delays in the running of official races caused by totalizator malfunctions are reported to the stewards. The mutuel manager shall submit a written report on any delay when requested by the state steward.

491—9.5(99D) Trainer and driver responsibilities.

9.5(1) *Trainer.*

a. Responsibility. The trainer is responsible for:

(1) The condition of horses entered in any race and, in the absence of substantial evidence to the contrary, for the presence of any prohibited drug, medication, or other substance, including permitted medication in excess of the maximum allowable level, in such horses, regardless of the acts of third parties. A positive test for a prohibited drug, medication, or substance, including permitted medication in excess of the maximum allowable level, as reported by a commission-approved laboratory, is prima facie evidence of a violation of this rule or Iowa Code chapter 99D.

(2) Preventing the administration of any drug, medication, or other prohibited substance that may cause a violation of these rules.

(3) Any violation of rules regarding a claimed horse's participation in the race in which the trainer's horse is claimed.

(4) The condition and contents of stalls, tack rooms, feed rooms, sleeping rooms, and other areas which have been assigned to the trainer by the facility, and maintaining the assigned stable area in a clean, neat, and sanitary condition at all times.

(5) Ensuring that fire prevention rules are strictly observed in the assigned stable area.

(6) Being present to witness the administration of furosemide during the administration time and sign as the witness on the affidavit form. A licensed designee of the trainer may witness the administration of the furosemide and sign as the witness on the affidavit form; however, this designee may not be another practicing veterinarian or veterinary assistant.

(7) The proper identity, custody, care, health, condition, and safety of horses in the trainer's charge.

(8) Disclosure to the racing secretary of the true and entire ownership of each horse in the trainer's care, custody, or control. Any change in ownership shall be, subject to approval of the stewards, reported immediately to and recorded by the racing secretary. The disclosure, together with all written agreements and affidavits setting out oral agreements pertaining to the ownership for or rights in and to a horse, shall be attached to the registration certificate for the horse and filed with the racing secretary.

(9) Training all horses owned wholly or in part by the trainer which are participating at the race meeting, unless otherwise approved by the stewards.

(10) Registering with the racing secretary each horse in the trainer's charge within 24 hours of the horse's arrival on facility premises.

(11) Ensuring that, at the time of arrival at the facility, each horse in the trainer's care is accompanied by a valid health certificate and evidence of a negative Coggins test, which shall be filed with the racing secretary.

(12) Having each horse in the trainer's care that is racing or stabled on facility premises tested for equine infectious anemia (EIA) in accordance with state law and for filing evidence of such negative test results with the racing secretary. The test must have been conducted within the previous 12 months and must be repeated upon expiration. The certificate must be attached to the eligibility certificate or on file with the racing secretary.

(13) Using the services of those veterinarians licensed by the commission to attend horses that are on facility premises.

(14) Immediately reporting the alteration of the sex of a horse in the trainer's care to the horse identifier and the racing secretary.

(15) Promptly reporting to the racing secretary and the commission veterinarian any horse on which a posterior digital neurectomy (heel nerving) has been performed and ensuring that such fact is designated on its certificate of registration or on file with the state veterinarian's office. See Iowa Code subsections 99D.25(1) to 99D.25(3).

(16) Promptly reporting to the stewards and the commission veterinarian the serious illness of any horse in the trainer's charge.

(17) Promptly reporting the death of any horse on facility premises in the trainer's care to the stewards, owner, and the commission veterinarian and complying with Iowa Code subsection 99D.25(5) governing postmortem examination.

(18) Maintaining a knowledge of the medication record and status of all horses in the trainer's care.

(19) Immediately reporting to the stewards and the commission veterinarian if the trainer knows, or has cause to believe, that a horse in the trainer's custody, care, or control has received any prohibited drugs or medication.

(20) Representing an owner in making entries and scratches and in all other matters pertaining to racing.

(21) Ensuring the eligibility of horses entered and allowances claimed.

(22) Ensuring the fitness of a horse to perform creditably at the distance entered.

(23) Ensuring that the trainer's horses are properly shod, bandaged, and equipped.

(24) Presenting the trainer's horse in the paddock at least one hour before post time or at a time otherwise appointed before the race in which the horse is entered.

(25) Personally attending to the trainer's horses in the paddock and supervising the harnessing thereof, unless excused by the stewards.

(26) Instructing the driver to give the driver's best effort during a race and instructing the driver that each horse shall be driven to win.

(27) Witnessing the collection of a urine or blood sample from the horse in the trainer's charge or delegating a licensed employee or the owner of the horse to do so.

(28) Notifying horse owners upon the revocation or suspension of the trainer's license. Upon application by the owner, the stewards may approve the transfer of such horses to the care of another licensed trainer and, upon such approved transfer, such horses may be entered to race.

(29) Securing the services of a driver prior to making a declaration.

b. Restrictions on wagering. A trainer with a horse(s) entered in a race shall be allowed to wager only on that horse(s) or that horse(s) in combination with other horses.

c. Assistant trainers.

(1) Upon the demonstration of a valid need, a trainer may employ an assistant trainer as approved by the stewards. The assistant trainer shall be licensed prior to acting in such capacity on behalf of the trainer.

(2) Qualifications for obtaining an assistant trainer's license shall be prescribed by the stewards and the commission and may include requirements set forth in 491—Chapter 6.

(3) An assistant trainer may substitute for and shall assume the same duties, responsibilities, and restrictions as are imposed on the licensed trainer. In such case, the trainer shall be jointly responsible for the assistant trainer's compliance with the rules.

d. Substitute trainers.

(1) A trainer absent for more than five days from responsibility as a licensed trainer, or on a day in which the trainer has a horse in a race, shall obtain another licensed trainer to substitute.

(2) A substitute trainer shall accept responsibility for the horses in writing and shall be approved by the stewards.

(3) A substitute trainer and the absent trainer shall be jointly responsible as absolute ensurers of the condition of their horses entered in an official workout or race.

9.5(2) *Driver.*

a. Driving duty. Every driver shall participate when programmed unless excused by the stewards. A driver shall give a best effort during a race and each horse shall be driven to win.

b. Driving colors. Drivers must wear distinguishing colors and clean white pants and shall not be allowed to start in a race unless, in the opinion of the stewards, they are properly dressed. No person shall drive a horse during the time when colors are required on the racetrack unless the person is wearing a protective helmet, painted as registered or of compatible colors, and has a chin strap in place.

c. Driver betting. No driver shall bet, or cause any other person to bet on the driver's behalf, on any other horse in any race in which the driver shall start a horse driven by the driver. No such person shall participate in exacta, quinella, or other multiple-pool wagering on a race in which such horse starts other than the daily double.

d. Fine, suspension or both. A fine, suspension or both may be applied to any driver for:

(1) Delaying the start;

(2) Failure to obey the starter's instructions;

(3) Rushing ahead of the inside or outside wing of the gate;

(4) Coming to the starting gate out of position;

(5) Crossing over before reaching the starting point;

(6) Interference with another horse or driver during the start or during the running of the race; or

(7) Failure to come up into position and remain in position.

491—9.6(99D) Conduct of races.

9.6(1) *Horses ineligible.* Any horse ineligible to be entered for a race, or ineligible to start in any race, that competes in that race may be disqualified and the stewards may discipline the persons responsible for that horse competing in that race. A horse is ineligible to start a race when:

a. The horse is not stabled on the premises of the licensed facility by the time so designated by the stewards;

b. The U.S.T.A. or C.T.A. eligibility certificate or electronic eligibility certificate has not been examined by the racing secretary, or horse identifier, and determined to be proper and in order;

c. The horse is not fully identified by an official tattoo on the inside of the upper lip or a freeze brand applied by an authorized U.S.T.A. or C.T.A. technician;

d. With respect to a horse that is entered for the first time, the nominator has failed to identify the horse by name, color, sex, age, names of sire and dam as registered, and present owner and trainer;

e. The horse is brought to the paddock and is not in the care of and harnessed by a licensed trainer or assistant trainer;

f. The horse has been knowingly entered or raced in any jurisdiction under a different name, with an altered eligibility certificate or electronic eligibility certificate, or altered lip tattoo by a person having lawful custody or control of the horse for the purpose of deceiving any facility or regulatory agency;

g. The horse has been allowed to enter or start by a person having lawful custody or control of the horse who participated in or assisted in the entry of racing of some other horse under the name of the horse in question;

h. The horse is wholly or partially owned by a disqualified person or is under the direct or indirect management of a disqualified person;

i. The horse is wholly or partially owned by the spouse of a disqualified person or is under the direct or indirect management of the spouse of a disqualified person; in such cases, it is presumed that the disqualified person and spouse constitute a single financial entry with respect to the horse, which presumption may be rebutted;

j. The horse has no current negative Coggins test certificate or negative equine infectious anemia test certificate attached to the eligibility certificate or on file with the racing secretary;

k. The stakes or entrance money for the horse has not been paid;

l. The horse appears on the starter's list, stewards' list, or veterinarian's list;

m. The horse is a first-time starter not meeting qualifications standards for the race meeting;

n. The horse is owned in whole or in part by an undisclosed person of interest;

o. The horse is subject to a lien that has not been approved by the stewards and filed with the horsemen's bookkeeper;

p. The horse is subject to a lease not filed with the stewards;

q. The horse is not in sound racing condition;

r. The horse has been nerved by surgical neurectomy;

s. The horse has been trachea-tubed to artificially assist breathing;

t. The horse has been blocked with alcohol or injected with any other foreign substance or drug to desensitize the nerves of the leg;

u. The horse has impaired eyesight in both eyes;

v. The horse appears on the starter's list, stewards' list, or veterinarian's list of any racing jurisdiction or is barred from racing in any racing jurisdiction; or

w. The horse has started in any race on the previous calendar day.

9.6(2) *Two-year-old horses.* No two-year-old horse shall be permitted to start in a dash or heat exceeding one mile in distance, and no two-year-old shall be permitted to race in more than two heats or dashes in any single day.

9.6(3) *Registration.* All matters relating to registration of standardbred horses shall be governed by the rules of the U.S.T.A.

9.6(4) *Eligibility certificate or electronic eligibility certificate.* A facility may refuse to accept any declaration without the eligibility certificate or electronic eligibility certificate for the proper gait first being presented. Fax or telephone declarations may be sent and accepted without penalty, provided the declarer furnished adequate program information, but the eligibility certificate or electronic eligibility certificate must be presented when the horse arrives at the facility and before it races. The racing secretary shall check each certificate and certify to the stewards as to the eligibility of all the horses.

9.6(5) *Canadian track information.* Prior to the declaration, owners of horses having Canadian certificates shall furnish the racing secretary with a Canadian certificate completely filled out for the current year, which has a U.S.T.A. validation certificate attached.

9.6(6) *Foreign entries.* No eligibility certificate or electronic eligibility certificate will be issued on a horse coming from a country other than Canada unless the following information, certified by the trotting association or governing body of that country from which the horse comes, is furnished:

a. The number of starts during the preceding year, together with the number of firsts, seconds, and thirds for the horse, and the total amount of money won during the current period.

b. The number of races in which the horse has started during the preceding year, together with the number of firsts, seconds, and thirds for the horse, and the total amount of money won during the current period.

c. A detailed list of the last six starts giving the date, place, track condition, post position or handicap, if it was a handicap race, distance of the race, position at the finish, the time of the race, the driver's name, and the first three horses in the race.

9.6(7) *Time bars.* No time records or bars shall be used as an element of eligibility.

9.6(8) *Date when eligibility is determined.*

a. Horses must be eligible when entries close but winnings on the closing date of eligibility shall not be considered.

b. In mixed races, trotting and pacing, a horse must be eligible to the class at the gait at which it is stated in the entry the horse will perform.

9.6(9) *Conflicting conditions.* In the event there are conflicting published conditions and neither is withdrawn by the facility, the more favorable to the nominator shall govern.

9.6(10) *Overnight events.*

a. Standards for overnight events. When time standards are established at a meeting for both trotters and pacers, trotters shall be given a minimum of two seconds allowance in relation to pacers.

b. Posting of overnight conditions. At extended pari-mutuel meetings, condition books will be prepared and races may be divided or substituted only when regularly scheduled races fail to fill. Books containing at least three days' racing programs will be available to horsemen at least 24 hours prior to closing declarations on any race program contained. When published, the conditions must be clearly stated and not printed as TBA—To Be Announced. The racing secretary shall forward copies of each condition book and overnight sheet to the commission and U.S.T.A. office as soon as they are available to the horsemen.

9.6(11) *Supplemental purse payments.* Supplemental purse payments made by a track after the termination of a meeting will be charged and credited to the winnings of any horse at the end of the racing year in which they

are distributed and will appear on the eligibility certificate or electronic eligibility certificate for the subsequent year. Distribution shall not affect the current eligibility until placed on the next eligibility certificate or electronic eligibility certificate.

9.6(12) *Substitute and divided races.*

a. Substitute races may be provided for each day's program and shall be so designated. Entries in races not filling shall be posted. A substitute race or a race divided into two divisions shall be used only if regularly scheduled races fail to fill.

b. If a regular race fills, it shall be raced on the day it was offered.

c. Overnight events and substitutes shall not be carried over to the next racing day.

9.6(13) *Qualifying races.* A horse qualifying in a qualifying race for which no purse is offered shall not be deprived by reason of that performance of the right to start in any conditioned race.

9.6(14) *Start.* The definition of the word "start" in any type of condition unless specifically so stated will include only those performances in a purse race. Qualifying and matinee races are excluded.

9.6(15) *Claiming races.*

a. Eligibility.

(1) No person may file a claim for any horse unless the person:

1. Is a licensed owner at the meeting who has started a horse at the meeting. A temporary horse owner's license is not valid for claiming purposes; or

2. Is a licensed authorized agent, authorized to claim for an owner eligible to claim; or

3. Has a valid open claim certificate. Any person not licensed as an owner, or a licensed authorized agent for the account of the same, or a licensed owner who has not started a horse at the meeting may request an open claim certificate from the commission. The person must submit a completed application for a prospective owner's license to the commission. The applicant must give the name of the trainer licensed by the commission who will be responsible for the claimed horse. A nonrefundable fee must accompany the application along with any financial information requested by the commission. The names of the prospective owners shall be prominently displayed in the offices of the commission and the racing secretary. The application will be processed by the commission and when the open claim certificate is exercised, an owner's license will be issued.

(2) One stable claim. No stable that consists of horses owned by more than one person and which has a single trainer may submit more than one claim in any race. An authorized agent may submit only one claim in any race regardless of the number of owners represented.

b. Procedure for claiming. To make a claim for a horse, an eligible person shall:

(1) Deposit to the person's account with the horsemen's bookkeeper the full claiming price and applicable taxes as established by the racing secretary's conditions.

(2) File in a locked claim box, maintained for that purpose by the stewards or their designee, a claim filled out completely in writing and with sufficient accuracy to identify the claim on forms provided by the facility at least ten minutes before the time of the race.

c. Claim box.

(1) The claim box shall be approved by the commission and kept locked until ten minutes prior to the start of the race when it shall be presented to the stewards or their representative for opening and publication of the claims.

(2) The claim box shall include a time clock which automatically stamps the time on the claim envelope prior to its being dropped in the box.

(3) No official of a facility shall give any information as to the filing of claims therein until after the race has been run.

d. Claim irrevocable. After a claim has been filed in the claim box, it shall not be withdrawn.

e. Multiple claims on single horses. If more than one claim is filed on a horse, the successful claim shall be determined by lot conducted by the stewards or their representatives.

f. Successful claims; later races.

(1) Sale or transfer. No successful claimant may sell or transfer a horse, except in a claiming race, for a period of 30 days from the date of claim.

(2) Eligibility price. A horse that is declared the official winner in the race in which it is claimed may not start in a race in which the claiming price is less than the amount for which it was claimed. After the first start back or 30 days, whichever occurs first, a horse may start for any claiming price. A horse which is not the official winner in the race in which it is claimed may start for any claiming price. No right, title, or interest for any claimed

horse shall be sold or transferred except in a claiming race for a period of 30 days following the date of claiming. The day claimed shall not count, but the following calendar day shall be the first day.

(3) Racing elsewhere. A horse that was claimed under these rules may not participate at a race meeting other than that at which it was claimed until the end of the meeting, except with written permission of the stewards. This limitation shall not apply to stakes races.

(4) Same management. A claimed horse shall not remain in the same stable or under the control or management of its former owner.

(5) When a horse is claimed out of a claiming race, the horse's engagements are included.

g. Transfer after claim.

(1) Forms. Upon a successful claim, the stewards shall issue in triplicate, upon forms approved by the commission, an authorization of transfer of the horse from the original owner to the claimant. Copies of the transfer authorization shall be forwarded to and maintained by the commission, the stewards, and the racing secretary. No claimed horse shall be delivered by the original owner to the successful claimant until authorized by the stewards. Every horse claimed shall race for the account of the original owner, but title to the horse shall be transferred to the claimant from the time the horse becomes a starter. The successful claimant shall become the owner of the horse at the time of starting, regardless of whether it is alive or dead, sound or unsound, or injured during or after the race. The original trainer of the claimed horse shall be responsible for the postrace test results.

(2) Other jurisdiction rules. The commission will recognize and be governed by the rules of any other jurisdiction regulating title and claiming races when ownership of a horse is transferred or affected by a claiming race conducted in that other jurisdiction.

(3) Determination of sex and age. The claimant shall be responsible for determining the age and sex of the horse claimed notwithstanding any designation of sex and age appearing in the program or in any racing publication. In the event of a spayed mare, the (s) for spayed should appear next to the mare's name on the program. If it does not, and the claimant finds that the mare is in fact spayed, claimant may then return the mare for full refund of the claiming price.

(4) Affidavit by claimant. The stewards may, if they determine it necessary, require any claimant to execute a sworn statement that the claimant is claiming the horse for the claimant's own account or as an authorized agent for a principal and not for any other person.

(5) Delivery required. No person shall refuse to deliver a properly claimed horse to the successful claimant. The claimed horse shall be disqualified from entering any race until delivery is made to the claimant.

(6) Obstructing rules of claiming. No person or licensee shall obstruct or interfere with another person or licensee in claiming any horse, enter into any agreement with another to subvert or defeat the object and procedures of a claiming race, or attempt to prevent any horse entered from being claimed.

h. Elimination of stable. An owner whose stable has been eliminated by claiming may claim for the remainder of the meeting at which eliminated or for 30 racing days, whichever is longer. With the permission of the stewards, stables eliminated by fire or other casualty may claim under this rule.

i. Deceptive claim. The stewards may cancel and disallow any claim within 24 hours after a race if they determine that a claim was made upon the basis of a lease, sale, or entry of a horse made for the purpose of fraudulently obtaining the privilege of making a claim. In the event of a disallowance, the stewards may further order the return of a horse to its original owner and the return of all claim moneys.

j. Protest of claim. A protest to any claim must be filed with the stewards before noon of the day following the date of the race in which the horse was claimed. Nonracing days are excluded from this rule.

9.6(16) *Entries.* All entries must:

a. Be made in writing.

b. Be signed by the owner or authorized agent, except as provided in this chapter.

c. Give name and address of the owner and agent or registered stable name or lessee.

d. Give name, color, sex, sire, and dam of horse.

e. Name the event or events in which the horse is to be entered.

9.6(17) *Entries and starters; split races.*

a. Entries required. The facility must specify how many entries are required for overnight events and, after the condition is fulfilled, the event must be contested.

b. Elimination heats or two divisions. In any race where the number of horses declared to start exceeds 11 on a half-mile track, or 14 on a larger track, unless lesser numbers are specified in the conditions of the race, the race, at the option of the facility and stated before positions are drawn, may be raced in elimination heats.

In the absence of conditions providing for a lesser number of starters, no more than two tiers of horses, allowing eight feet per horse, will be allowed to start in any race.

c. Elimination plans.

(1) Whenever elimination heats are required, or specified in the published conditions, the race shall be raced in the following manner unless otherwise stated in the conditions or conducted under another segment of these rules. The field shall be divided by lot and the first division shall race a qualifying dash for 30 percent of the purse, the second division shall race a qualifying dash for 30 percent of the purse, and the horses so qualified shall race in the main event for 40 percent of the purse. The winner of the main event shall be the race winner.

(2) In the event there are more horses declared to start than can be accommodated by the two elimination dashes, there shall be added enough elimination dashes to take care of the excess. The percent of the purse raced for each elimination dash will be determined by dividing the number of elimination dashes into 60. The main event will race for 40 percent of the purse.

1. Draw positions to determine which of the dash winners has the pole and which the second position; which of the two horses that have been second shall start in third position and which in fourth; and subsequent positions, or

2. Have an open draw to determine the positions in which the horses are to start in the main event; that is, all positions shall be drawn by lot from among all horses qualified for the main event. In the event the sponsor fails to prescribe in the conditions for the event the method to be used for the drawing of post positions, the provisions of paragraph "1" above shall apply.

d. Overnight events. In overnight events at extended pari-mutuel meetings, not more than eight horses shall be allowed to start on a half-mile track and not more than ten horses on larger tracks.

e. Qualifying race for stake. Where qualifying races are provided in the conditions of any early closing event, stakes, or futurity, the qualifying race must be held not more than seven days prior to contesting the main event, omitting the day of the race.

9.6(18) *Declaration to start; drawing horses.*

a. Declaration.

(1) Declaration time shall be determined by the stewards.

(2) No horse shall be declared to start in more than one race on any one racing day.

(3) Declaration box (box). The facility shall provide a locked box with an aperture through which declarations shall be deposited.

(4) Responsibility for box. The stewards shall be in charge of the box.

(5) Search for declarations by the steward(s) before opening box. Just prior to opening of the box at extended pari-mutuel meetings where futurities, stakes, early closing, or late closing events are on the program, the steward(s) shall check with the racing secretary to ascertain if any declarations by mail, fax, or otherwise are in the office and not deposited in the box and shall see that they are declared and drawn in the proper event.

(6) Opening of box. The box shall be opened by the steward(s) at the advertised time and the steward(s) will be responsible for ensuring that at least one horseman or the horseman's official representative is present. No owner or agent for a horse with a declaration in the box shall be denied the privilege of being present. Under the supervision of the steward(s), all declarations shall be listed, the eligibility verified, the preference ascertained, starters selected, and post positions drawn. If it is necessary to reopen any race, public announcement shall be made at least twice and the box reopened at a defined time.

(7) Drawing of post positions for heats in races of more than one dash or heat. In races of a duration of more than one dash or heat, the stewards may draw post positions from the stand for succeeding dashes or heats.

(8) Declarations by mail, fax, or telephone. Declarations by mail, fax, or telephone actually received and evidence of which is deposited in the box before the time specified to declare shall be drawn in the same manner as the others. Drawings shall be final. Mail, fax, and telephone declarations must state the name and address of the owner or lessee; the name, color, sex, sire and dam of the horse; the name of the driver and colors; the date and place of last start; a current summary, including the number of starts, firsts, seconds, thirds, earnings, and best winning time for the current year; and the event or events in which the horse is to be entered.

(9) Effect of failure to declare on time. When a facility requires a horse to be declared by a stated time, failure to declare as required shall be considered a withdrawal from the event.

(10) Drawings of horses after declaration. After declaration to start has been made, no horse shall be drawn except by permission of the stewards.

(11) Horses omitted through error. Drawings shall be final unless there is conclusive evidence that a horse properly declared was omitted from the race through the error of the facility or its agent or employee, in which event the horse shall be added to the race but given the last post position, provided the error is discovered prior to scratch time or the printing of the program, whichever is sooner. However, in the case of early closers and stake and futurity races, the race shall be redrawn.

b. Qualifying races. At all extended pari-mutuel meetings, eligibility to declare for overnight events shall be governed by the following:

(1) Within 30 days of being declared in, a horse that has not raced previously at the gait chosen must go through a qualifying race under the supervision of a steward and acquire at least one charted line by a licensed charter. In order to provide complete and accurate chart information on time and beaten lengths, a standard photo finish shall be in use.

(2) A horse that does not show a charted line for the previous season or a charted line within its last six starts must go through a qualifying race as set forth above. Uncharted races contested in heats of more than one dash and consolidated according to subparagraph 9.6(18)*"b"*(4) below will be considered one start.

(3) A horse that has not started at a charted meeting by April 1 of a season must go through a qualifying race and meet the qualifying standards of the meet.

(4) When a horse has raced at a charted meeting during the current season, then gone to meetings where the races are not charted, the information from the uncharted races may be summarized, including each start, and consolidated in favor of charted lines. The requirements of subparagraph 9.6(18)*"b"*(2) above would not then apply.

(5) The consolidated line shall carry date, place, time, driver, finish, track condition, and distance if race is not at one mile.

(6) The stewards may require any horse that has been on the stewards' list to go through a qualifying race. A horse that is on the stewards' list for breaks or refusing to come to the gate must qualify in a qualifying race.

(7) If a horse has not raced an individual time meeting the qualifying standards for that class of horse, the horse may be required to go through a qualifying race.

(8) The stewards may permit a fast horse to qualify by means of a timed workout consistent with the time of the races in which it will compete in the event adequate competition is not available for a qualifying race.

(9) To enable a horse to qualify, qualifying races should be held at least one full week prior to the opening of any meeting and shall be scheduled once a week during the meeting and through the last week of the meeting.

(10) When a race is conducted for the purpose of qualifying drivers and not horses, the race need not be charted, timed, or recorded. This subparagraph is not applicable to races qualifying both drivers and horses.

(11) If a horse takes a win race record in a qualifying race, the record must be prefaced with the letter "Q" wherever it appears, except in a case where, immediately prior to or following the race, the horse taking the record has had a specimen taken and tested. It will be the responsibility of the steward to report the results of the test on the stewards' sheet.

(12) Any horse that fails to race at a charted meeting within 30 days after having started in a current year shall start in a charted race or a qualifying race and meet the standards of the meeting before being allowed to start.

c. Coupled entries.

(1) When one owner or lessee enters more than one horse in the same race, the horses shall be coupled as an entry. Horses shall be regarded as having a common owner when an owner of one horse, either as an individual, a licensed member of a partnership, or a licensed shareholder of a corporation, has an aggregate commonality of ownership of 5 percent interest in another horse, either as an individual, a licensed member of a partnership, or a licensed shareholder of a corporation. If the race is split in two or more divisions, horses in an "entry" shall be seeded insofar as possible, first by owners, then by trainer, then by stables; but the divisions in which the horses compete and their post positions shall be drawn by lot. The above provision shall also apply to elimination heats.

(2) Coupled entry limitations on owner. No more than two horses coupled by a common ownership or trainer shall be entered in an overnight race.

(3) Coupling entries by stewards. The stewards shall couple as a single entry any horses which, in the determination of the stewards, are connected by common ownership, common lessee, or when the stewards determine that coupling is necessary in the interest of the regulation of a pari-mutuel wagering industry or is necessary to ensure the public's confidence in racing.

d. Also eligibles. No more than two horses may be drawn as also eligibles for a race and their positions shall be drawn along with the starters in the race. In the event one or more horses are excused by the stewards, the

also eligible horse(s) shall race and take the post position drawn by the horse that it replaces, except in handicap races. In handicap races the also eligible horse shall take the place of the horse that it replaces in the event that the handicap is the same. In the event the handicap is different, the also eligible horse shall take the position on the outside of horses with a similar handicap. No horse may be added to a race as an also eligible unless the horse was drawn as such at the time declarations closed. No horse may be barred from a race to which it is otherwise eligible by reason of its preference due to the fact that it has been drawn as an also eligible. A horse put into the race from the also eligible list cannot be drawn except by permission of the stewards, but the owner or trainer of the horse shall be notified that the horse is to race and the notification shall be posted at the racing secretary's office. All horses on the also eligible list and not moved into the race by scratch time for the race shall be released.

e. Preference.

(1) Preference shall be given in all overnight events according to a horse's last purse race during the current year. The preference date on a horse that has drawn to race and been scratched is the date of the race from which it was scratched.

(2) When a horse is racing for the first time in the current year, the date of the first successful qualifying race shall be considered its last race date and preference shall be applied accordingly.

(3) If an error has been made in determining or posting a preference date and the error deprives an eligible horse of an opportunity to race, the trainer involved shall report the error to the racing secretary within one hour of the announcement of the draw. If in fact a preference date error has occurred, the race will be redrawn.

(4) Exclusion of single interest. Horses having the same owner, lessee, or trainer shall not be permitted to enter or start if the effect would deprive a single interest from starting in overnight races.

(5) Whenever horses have equal preference in a race, the actual preference of said horses in relation to one another shall be determined from the most recent previous starts which do not result in equal preference.

(6) When an overnight race has been reopened because it did not fill, all eligible horses declared into the race prior to the reopening shall receive preference over other horses subsequently declared, irrespective of the actual preference dates.

f. Stewards' list.

(1) A horse that is unfit to race because it is dangerous, unmanageable, sick, lame, unable to show a performance to qualify for races at the meeting, or is otherwise unfit to race at the meeting, may be placed on a stewards' list by the stewards, and declarations of the horse shall be refused. The owner or trainer shall be notified in writing of such action and the reason as set forth above shall be clearly stated on the notice. When any horse is placed on the stewards' list, the clerk of the course shall make a note on the certificate or electronic eligibility certificate of such horse showing the date the horse was put on the stewards' list, the reason, and the date of removal if the horse has been removed.

(2) No steward or other official at a nonextended meeting shall have the power to remove from the stewards' list and accept as an entry any horse which has been placed on a stewards' list for the reason that it is a dangerous or unmanageable horse. Meetings may refuse declarations on any horse that has been placed on the stewards' list and has not been removed.

(3) A horse scratched from a race because of lameness or sickness may not race or enter another race for at least three days from the date scheduled to race.

g. Driver. Declarations shall state who shall drive the horse and give the driver's colors. Drivers shall be named at the time of the draw after which no driver may be changed without good cause and permission of the steward(s). All drivers must be changed by scratch time. When a nominator starts two or more horses, the stewards shall approve or disapprove the second and third drivers.

9.6(19) *Starting.*

a. With starting gate.

(1) Starter's control. The starter shall have control of the horses from the formation of the parade until giving the word "go."

(2) Scoring. After one or two preliminary warming up scores, the starter shall notify the drivers to fasten their helmets and come to the starting gate. During or before the parade, the drivers must be informed as to the number of scores permitted.

(3) Starting gate. The horses shall be brought to the starting gate as near to one-quarter of a mile before the start as the facility will permit.

(4) Speed of gate. Allowing sufficient time so that the speed of the gate can be increased gradually, the following minimum speeds will be maintained.

1. For the first one-eighth mile, not less than 11 miles per hour.
2. For the next one-sixteenth of a mile, not less than 18 miles per hour.
3. From the above point to the starting point, the speed will be increased gradually to maximum speed.

(5) On mile tracks, horses will be brought to the starting gate at the head of the stretch, and the relative speeds stated in subparagraph (4) of this subrule will be maintained.

(6) The starting point will be a point on the inside rail a distance of not less than 200 feet from the first turn. The starter shall give the word "go" at the starting point.

(7) When a speed has been reached in the course of a start, there shall be no decrease except in the case of a recall.

(8) Recall notice. In case of a recall, a light plainly visible to the drivers shall be flashed and a recall sounded, and whenever possible the starter shall leave the wings of the gate extended and gradually slow the speed of the gate to assist in stopping the field of horses. In an emergency, the starter shall use discretion to close the wings of the gate.

(9) There shall be no recall after the word "go" has been given and any horse, regardless of position or an accident, shall be deemed a starter from the time entered into the starter's control unless dismissed by the starter.

(10) Breaking horse. The starter shall endeavor to get all horses away in position and on gait but there shall be no recall for a breaking horse.

(11) Reason for recall. The starter may sound a recall only for the following reasons:

1. A horse scores ahead of the gate.
2. There is interference.
3. A horse has broken equipment.
4. A horse falls before the word "go" is given.
5. A starting gate malfunctions.
6. A horse comes to the starting gate out of position.

(12) Riding in gate. No person(s) shall be allowed to ride in the starting gate except the starter, driver or operator, and a patrol judge unless permission has been granted by the stewards.

(13) Loudspeaker. Use of a mechanical loudspeaker for any purpose other than to give instructions to drivers is prohibited. The volume shall be no higher than necessary to carry the voice of the starter to the drivers.

b. Holding horses before start. Horses may be held on the backstretch not to exceed two minutes awaiting post time, except when delayed by an emergency.

c. Two tiers. In the event there are two tiers of horses, the withdrawing of a horse that has drawn or earned a position in the front tier shall not affect the position of the horses that have drawn or earned positions in the second tier. Whenever a horse is withdrawn from any tier, horses on the outside shall move in to fill up the vacancy.

d. Starters. The horses shall be deemed to have started when the word "go" is given by the starter and all the horses must go the course except in case of an accident, broken equipment, or any other reason in which the stewards determine that it is impossible to go the course.

e. Unmanageable horse.

(1) If, in the opinion of the stewards or the starter, a horse is unmanageable or liable to cause accidents or injury to any other horse or to any driver, it may be sent to the barn. When this action is taken, the stewards will notify the public.

(2) A horse shall be considered unmanageable if it causes more than one recall in the same dash or heat and the horse shall be excused by the starter.

f. Post positions; heat racing. The horse winning the first heat shall take the pole (or inside position) in the succeeding heat, unless otherwise specified in the published conditions, and all others shall take their positions in the order they were placed in the last heat. When two or more horses have made a dead heat, their positions shall be settled by lot.

9.6(20) *Racing and track.*

a. Although a leading horse is entitled to any part of the track, except after selecting its position in the home stretch, neither the driver of the first horse nor any other driver in the race shall do any of the following:

(1) Change either to the right or left during any part of the race when another horse is so near that altering its position compels the horse behind to shorten its stride or causes the driver of the other horse to pull out of its stride.

(2) Jostle, strike, hook wheels, or interfere with another horse or driver.

(3) Cross sharply in front of a horse or cross over in front of a field of horses in a reckless manner, endangering other drivers.

(4) Swerve in and out or pull up quickly.

(5) Crowd a horse or driver by "putting a wheel under them."

(6) "Carry a horse out" or "sit down in front" of a horse or take up abruptly in front of other horses so as to cause confusion or interference among the trailing horses.

(7) Let a horse pass inside needlessly or otherwise help another horse to improve its position in the race.

(8) Lay off a normal pace and leave a hole when it is well within the horse's capacity to keep the hole closed.

(9) Commit any act which shall impede the progress of another horse or cause it to "break."

(10) Change course after selecting a position in the home stretch, swerve in or out, or bear in or out to interfere with another horse or cause it to change course or take back.

(11) Drive in a careless or reckless manner.

(12) Whip under the arch of the sulky.

(13) Kick the horse.

(14) Fail to set or maintain a pace comparable to the class in which the driver is racing by going an excessively slow quarter or any other distance that changes the normal pattern, overall timing, or general outcome of the race.

(15) Cross the inside limits of the course.

b. Complaints—reports of interference.

(1) Complaints. All complaints by drivers of any foul driving or other misconduct during the heat must be made to the starter at the termination of the heat, unless the driver is prevented from doing so by an accident or injury. Any driver desiring to enter a claim of foul or other complaint of violation of the rules must, before dismounting, indicate to the starter the desire to enter the claim or complaint and, upon dismounting, shall proceed to the telephone or stewards' stand where the claim, objection, or complaint shall be immediately entered. The stewards shall not cause the official sign to be displayed until the claim, objection, or complaint has been entered and considered.

(2) Report of interference. It is the duty of every driver to report to the official designated for that purpose, as promptly as possible after the conclusion of a race in which the driver has participated, any material interference to the driver or the horse by another horse or driver during a race.

c. If any of the above violations are committed by a person driving a horse coupled as an entry in the betting, the stewards shall set the offending horse back. The horse coupled in the entry with the offending horse shall also be set back if the stewards find that it improved its finishing position as a direct result of the offense committed by the offending horse.

d. In the case of interference, collision, or violation of any of the above restrictions, whether occurring before or after the start, the offending horse may be placed back one or more positions in that heat or dash and, in the event the collision or interference prevents any horse from finishing the heat or dash, the offending horse may be disqualified from receiving any winnings; and the driver may be subject to discipline. In the event a horse is set back, it must be placed behind the horse with whom it interfered.

e. Unsatisfactory drive—fraud. Every heat in a race must be contested by every horse in the race and every horse must be driven to the finish. If the stewards believe that a horse is being driven or has been driven to prevent winning a heat or dash which it was evidently able to win, in an inconsistent manner, or to perpetrate or to aid a fraud, they shall consider it a violation and the driver and anyone in concert with the driver to so affect the outcome of the race(s) may be subject to disciplinary action. The stewards may substitute a competent and reliable driver at any time. The substitute driver shall be paid at the discretion of the stewards and the fee shall be retained from the purse money due the horse, if any.

In the event a drive is unsatisfactory due to lack of effort or carelessness, and the stewards believe that there is no fraud, gross carelessness, or a deliberate inconsistent drive, they shall impose a penalty.

f. If, in the opinion of the stewards, a driver is for any reason unfit or incompetent to drive, refuses to comply with the directions of the stewards, or is reckless in conduct and endangers the safety of horses or other drivers in the race, the driver may be removed and another driver substituted at any time after the positions have been assigned in a race, and the offending driver shall be subject to discipline. The substitute driver shall be properly compensated.

g. If, for any cause other than being interfered with or broken equipment, a horse fails to finish after starting in a heat, that horse shall be ruled out.

h. Loud shouting or other improper conduct is forbidden in a race. After the starting gate is in motion, both feet must be kept in the stirrups until after the finish of the race, except that a driver shall be allowed to remove a foot from the stirrups temporarily for the purpose of pulling earplugs.

i. Drivers will be allowed whips not to exceed three feet nine inches, plus a snapper not longer than six inches. Provided further that the following actions may be considered as excessive or indiscriminate use of the whip:

(1) Causing visible injury to a horse.

(2) Whipping a horse after a race.

j. A driver using any goading device, chain, or mechanical devices or appliances, other than the ordinary whip or crop, upon any horse in any race shall be subject to discipline.

k. The brutal, excessive, or indiscriminate use of the whip or crop shall be considered a violation. A driver may use a whip only in the conventional manner. Welts, cuts, or whip marks on a horse resulting from whipping shall constitute a violation of this subrule. Drivers are prohibited from punching or jabbing a horse, or using the whip so as to interfere with or cause disturbance to any other horse or driver in a race.

l. No horse shall wear hopples in a race unless it starts with the hopples in the first heat and, having so started, it shall continue to wear them to the finish of the race. Any person found guilty of removing or altering a horse's hopples during a race, or between races, for the purpose of fraud, shall be suspended or expelled. Any horse habitually wearing hopples shall not be permitted to start in a race without them except by permission of the stewards. Any horse habitually racing free-legged shall not be permitted to wear hopples in a race except with the permission of the stewards. No horse shall be permitted to wear a head pole protruding beyond its nose.

m. Breaking.

(1) When any horse breaks from its gait in trotting or pacing, its driver shall at once, where clearance exists, take such horse to the outside and pull it to its gait.

(2) The following shall be considered violations of subparagraph 9.6(20)*"m"*(1):

1. Failure to properly attempt to pull the horse to its gait.
2. Failure to take to the outside where clearance exists.
3. Failure to lose ground by the break.

(3) Any breaking horse shall be set back when a contending horse on its gait is lapped on the hind quarter of the breaking horse at the finish.

(4) Any horse making a break which causes interference to other contending horses may be placed behind all offended horses; if there has been no failure on the part of the driver of the breaking horse in complying with subparagraph 9.6(20)*"m"*(2) above, no fine or suspension shall be imposed on the driver as a consequence of the interference.

(5) The stewards may set any horse back one or more places if, in their judgment, any of the above violations have been committed.

If, in the opinion of the stewards, a driver allows the horse to break for the purpose of fraudulently losing a heat, then the driver shall be subject to the penalties elsewhere provided for fraud and fouls.

To assist in determining the matters contained in paragraphs 9.6(20)*"m"* and 9.6(20)*"n,"* it shall be the duty of one of the stewards to call out every break made, and the clerk shall at once note the break and character of it in writing.

n. The time between separate heats of a single race shall be no less than 40 minutes. The time between the heats shall not exceed one hour and 30 minutes. No heat shall be called after sunset when the track is not lighted for night racing.

o. Horses called for a race shall have the exclusive right of the course, and all other horses shall vacate the track at once, unless permitted to remain by the stewards.

p. In the case of accidents, only so much time shall be allowed as the stewards may deem necessary and proper.

q. A driver must be mounted in the sulky at the finish of the race or the horse must be placed as not finishing.

r. It shall be the responsibility of the owner and trainer to provide every sulky used in a race with unicolored or colorless wheel discs on the inside and outside of the wheel of a type approved by the commission. In their discretion, the stewards may order the use of mudguards at pari-mutuel tracks.

s. Sulky. Only sulkies of the conventional dual-shaft and dual-hitch type shall be permitted to be used in any races. A conventional-type sulky is one having two shafts that must be parallel to and securely hitched on

each side of the horse. No point of hitch or any part of a shaft shall be above a horizontal level equal to the lowest point of the horse's back.

t. Excessive or unnecessary conversation between and among drivers while on the racetrack during the time when colors are required is prohibited.

u. If, at any racetrack which does not have a continuous solid inside hub rail, a horse or part of the horse sulky leaves the course by going inside the hub rail or other demarcation which constitutes the inside limits of the course, the offending horse shall be placed back one or more positions where, in the opinion of the stewards, the action gave the horse an unfair advantage over other horses in the race, or the action helped the horse improve its position in the race. In addition, when an act of interference causes a horse or part of the horse's sulky to cross the inside limits of the course, and the horse is placed by the judges, the offending horse shall be placed behind the horse with which it interfered.

9.6(21) *Protests.*

a. Protests may be made only by an owner, manager, trainer, or driver of one of the contending horses at any time before the winnings are paid over and shall be in writing, sworn to, and contain at least one specific charge, which, if true, would prevent the horse from winning or competing in the race.

b. The stewards shall in every case of protest demand that the driver, and the owner or owners if present, immediately testify under oath and, in case of their refusal to do so, the horse shall not be allowed to start or continue in the race, but shall be ruled out, with a forfeit of entrance money.

c. Unless the stewards find satisfactory evidence to warrant excluding the horse, they shall allow the horse to start or continue in the race under protest, and the premium, if any, won by that horse shall be forthwith transmitted to the commission to allow the parties interested an opportunity to sustain the allegation of the protest or furnish information which will warrant an investigation of the matter. When no action is taken to sustain the protest within 30 days, payment may be made as if such protest had not been filed.

d. Any person found guilty of protesting a horse falsely and without cause, or merely with intent to embarrass a race, shall be subject to discipline.

e. Nothing here contained shall affect the distribution of pari-mutuel pools when the distribution is made upon the official placing at the conclusion of the heat or dash.

f. In case of an appeal or protest, the purse money affected will be deposited with the commission in trust funds pending the decision of the appeal.

9.6(22) *Timing and records.*

a. Timing races. In every race, the time of each heat shall be accurately taken by three timers or an approved electric timing device, in which case there shall be one timer; placed in the record in minutes, seconds, and fifths of seconds; and, upon the decision of each heat, the time shall be publicly announced or posted. No unofficial timing shall be announced or admitted to the record and, when the timers fail to act, no time shall be announced or recorded for that heat.

b. Error in reported time. In any case of alleged error in the record, announcement, or publication of the time made by a horse, the time so questioned shall not be changed to favor the horse or owner, except upon the sworn statement of the stewards and timers who officiated in the race.

c. Time, where lapped on. The leading horse shall be timed and that time only shall be announced. No horse shall obtain a win race record by reason of the disqualification of another horse unless the horse's actual race time can be determined by photo finish or electronic timing.

d. Time for dead heat. In case of a dead heat, the time shall constitute a record for the horses making a dead heat and both shall be considered winners.

e. Timing procedure. The time shall be recorded from the instant that the first horse leaves the point from which the distance is measured until the first horse reaches the finish line. The time of the leading horse at the quarter, half, three-quarters and the finish shall be taken.

f. Fraudulent misrepresentation. Any person guilty of fraudulent misrepresentation of time or the alteration of the record in any public race shall be fined, suspended, or expelled, and the time declared not a record.

9.6(23) *Heat number and saddle pads; entry number.* Each competing horse shall be equipped with numbers of style, type, and design approved by the commission or its representatives. Numbers shall be so arranged that coupled entries may be distinguished.

9.6(24) *Paddock.* The paddock or receiving barn must be completely enclosed with a secure fence and each opening through the fence shall be policed by a person or persons licensed by this commission so as to exclude

unauthorized personnel. A daily record of all persons entering or leaving the paddock from one hour prior to post time until all races of that program have been completed shall be maintained on forms approved by the commission.

9.6(25) *Other facility conditions.*

a. Default in payment of purses. Any facility that defaults in the payment of a premium that has been raced for shall stand suspended, together with its officers.

b. If, at a meeting of a facility, a race is contested which has been promoted by another party or parties, and the promoters default in the payment of the amount raced for, the same liability shall attach to the facility as if the race had been offered by it.

c. Removal of horses from facility premises. No horse shall be ordered off the premises without at least 72 hours' notice (excluding Sunday) to the person in charge of the horse.

491—9.7(99D) Medication and administration, sample collection, chemists, and practicing veterinarian.

9.7(1) *Medication and administration.*

a. No horse, while participating in a race, shall carry in its body any medication, drug, foreign substance, or metabolic derivative thereof, which is a narcotic or which could serve as a local anesthetic or tranquilizer or which could stimulate or depress the circulatory, respiratory, or central nervous system of a horse, thereby affecting its speed.

b. Also prohibited are any drugs or foreign substances that might mask or screen the presence of the prohibited drugs, or prevent or delay testing procedures.

c. Proof of detection by the commission chemist of the presence of a medication, drug, foreign substance, or metabolic derivative thereof, prohibited by paragraph 9.7(1)*"a"* or *"b"* in a saliva, urine, or blood sample duly taken under the supervision of the commission veterinarian from a horse immediately prior to or promptly after running in a race shall be prima facie evidence that the horse was administered, with the intent that it would carry or that it did carry in its body while running in a race, prohibited medication, drug, or foreign substance in violation of this rule.

d. Administration or possession of drugs.

(1) No person shall administer, cause to be administered, participate or attempt to participate in any way in the administration of any medication, drug, foreign substance, or treatment by any route to a horse registered for racing on the day of the race for which the horse is entered prior to the race.

(2) No person except a veterinarian shall have in the person's possession any prescription drug. However, a person may possess a noninjectable prescription drug for animal use if:

1. The person actually possesses, within the racetrack enclosure, documentary evidence that a prescription has been issued to said person for such a prescription drug.

2. The prescription contains a specific dosage for the particular horse or horses to be treated by the prescription drug.

3. The horse or horses named in the prescription are in said person's care within the racetrack enclosure.

(3) No veterinarian or any other person shall have in their possession or administer to any horse within any racetrack enclosure any chemical substance which:

1. Has not been approved for use on equines by the Food and Drug Administration pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. Section 301 et seq., and implementing regulations, without the prior written approval from a commission veterinarian, after consulting with the stewards.

2. Is on any of the schedules of controlled substances as prepared by the Attorney General of the United States pursuant to 21 U.S.C. Sections 811 and 812, without the prior written approval from a commission veterinarian after consultation with the stewards. The commission veterinarian shall not give such approval unless the person seeking the approval can produce evidence in recognized veterinary journals or by recognized equine experts that such chemical substance has a beneficial therapeutic use in horses.

(4) No veterinarian or any other person shall dispense, sell, or furnish to any person any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route within the premises of the facility unless there is a label specifying the name of the substance dispensed, the name of the dispensing person, the name of the horse or horses for which the substance is dispensed, the purpose for which said substance is dispensed, the dispensing veterinarian's recommendations for withdrawal before racing (if applicable), and the name of the person to which dispensed, or is otherwise labeled as required by law.

(5) No person shall have in the person's possession or in areas under said person's responsibility on facility premises any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route unless it complies with the labeling requirements in 9.7(1)*"d"*(4).

e. Any person found to have administered or caused, participated in, or attempted to participate in any way in the administration of a medication, drug, or foreign substance that caused or could have caused a violation of this rule, shall be subject to disciplinary action.

f. The owner, trainer, groom, or any other person having charge, custody, or care of the horse is obligated to protect the horse properly and guard it against the administration or attempted administration of a substance in violation of this rule. If the stewards find that any person has failed to show proper protection and guarding of the horse, or if the stewards find that any owner, lessee, or trainer is guilty of negligence, they shall impose discipline and take other action they deem proper under any of the rules including referral to the commission.

g. In order for a horse to be placed on the bleeder list in Iowa through reciprocity, that horse must be certified as a bleeder in another state or jurisdiction. A certified bleeder is a horse that has raced with furosemide in another state or jurisdiction in compliance with the laws governing furosemide in that state or jurisdiction.

h. The possession or use of blood doping agents, including but not limited to those listed below, on the premises of a facility under the jurisdiction of the commission is forbidden:

(1) Erythropoietin;

(2) Darbepoetin;

(3) Oxyglobin®; and

(4) Hemopure®.

i. The use of extracorporeal shock wave therapy or radial pulse wave therapy machines shall not be permitted unless the following conditions are met:

(1) Any treated horse shall not be permitted to race for a minimum of ten days following treatment;

(2) The use of extracorporeal shock wave therapy or radial pulse wave therapy machines shall be limited to veterinarians licensed to practice by the commission;

(3) Any extracorporeal shock wave therapy or radial pulse wave therapy machines on the association grounds must be registered with and approved by the commission or its designee before use;

(4) All extracorporeal shock wave therapy or radial pulse wave therapy treatments must be reported to the official veterinarian on the prescribed form not later than the time prescribed by the official veterinarian.

j. The use of a nasogastric tube (a tube longer than six inches) for the administration of any substance within 24 hours prior to the post time of the race in which the horse is entered is prohibited without the prior permission of the official veterinarian or designee.

k. Non-steroidal anti-inflammatory drugs (NSAIDs).

(1) The use of one of three approved NSAIDs shall be permitted under the following conditions:

1. Not to exceed the following permitted serum or plasma threshold concentrations which are consistent with administration by a single intravenous injection at least 24 hours before the post time for the race in which the horse is entered:

- Phenylbutazone (or its metabolite oxyphenylbutazone) – 5 micrograms per milliliter;
- Flunixin – 20 nanograms per milliliter;
- Ketoprofen – 10 nanograms per milliliter.

2. The NSAIDs listed in numbered paragraph "1" or any other NSAIDs are prohibited from being administered within the 24 hours before post time for the race in which the horse is entered.

3. The presence of more than one of the three approved NSAIDs, with the exception of phenylbutazone in a concentration below 1 microgram per milliliter of serum or plasma, or the presence of any unapproved NSAID in the post race serum or plasma sample is not permitted. The use of all but one of the approved NSAIDs shall be discontinued at least 48 hours before the post time for the race in which the horse is entered.

(2) Any horse to which an NSAID has been administered shall be subject to having a blood sample(s), urine sample(s) or both taken at the direction of the official veterinarian to determine the quantitative NSAID level(s) or the presence of other drugs which may be present in the blood or urine sample(s).

9.7(2) *Sample collection.*

a. Urine, blood, and other specimens shall be taken and tested from any horse that the stewards, commission veterinarian, or the commission's representatives may designate. The samples shall be collected by the commission veterinarian or other person or persons the commission may designate. Each sample shall be marked or numbered and bear information essential to its proper analysis; but the identity of the horse from

which the sample was taken or the identity of its owners or trainer shall not be revealed to the official chemist or the staff of the chemist. The container of each sample shall be sealed as soon as the sample is placed therein.

b. A facility shall have a detention barn under the supervision of the commission veterinarian for the purpose of collecting body fluid samples for any tests required by the commission. The building, location, arrangement, furnishings, and facilities including refrigeration and hot and cold running water must be approved by the commission. A security guard, approved by the commission, must be in attendance at each access to the detention barn during the hours designated by the commission.

c. No unauthorized person shall be admitted at any time to the building or the area utilized for the purpose of collecting the required body fluid samples or the area designated for the retention of horses pending the obtaining of body fluid samples.

d. During the taking of samples from a horse, the owner, responsible trainer, or a representative designated by the owner or trainer may be present and witness the taking of the sample and so signify in writing. Failure to be present and witness the collection of the samples constitutes a waiver by the owner, trainer, or representative of any objections to the source and documentation of the sample.

e. The commission veterinarian, the stewards, agents of the division of criminal investigation, or commission representative may take samples of any medicine or other materials suspected of containing improper medication, drugs, or other substance which could affect the racing condition of a horse in a race, which may be found in barns or elsewhere on facility premises or in the possession of any person connected with racing, and the same shall be delivered to the official chemist for analysis.

f. Nothing in these rules shall be construed to prevent:

(1) Any horse in any race from being subjected by the order of a steward or the commission veterinarian to tests of body fluid samples for the purpose of determining the presence of any foreign substance.

(2) The state steward or the commission veterinarian from authorizing the splitting of any sample.

(3) The commission or commission veterinarian from requiring body fluid samples to be stored in a frozen state for future analysis.

g. Before leaving the racing surface, the trainer shall ascertain the testing status of the horse under the trainer's care from the commission veterinarian or designated detention barn representative.

9.7(3) *Chemists.*

a. Tests are to be under the supervision of the commission which shall employ one or more chemists or contract with one or more qualified chemical laboratories to determine by chemical testing and analysis of body fluid samples whether a foreign substance, medication, drug, or metabolic derivative thereof is present.

b. All body fluid samples taken by or under direction of the commission veterinarian or commission representative shall be delivered to the laboratory of the official chemist for analysis.

c. The commission chemist shall be responsible for safeguarding and testing each sample delivered to the laboratory by the commission veterinarian.

d. The commission chemist shall conduct individual tests on each sample, screening the samples for prohibited substances, and conducting other tests to detect and identify any suspected prohibited substance or metabolic derivative thereof with specificity. Pooling of samples shall be permitted only with the knowledge and approval of the commission.

e. Upon the finding of a test negative for prohibited substances, the remaining portions of the sample may be discarded. Upon the finding of tests suspicious or positive for prohibited substances, the tests shall be reconfirmed, and the remaining portion, if available, of the sample preserved and protected for two years following close of the meet.

f. The commission chemist shall submit to the commission a written report as to each sample tested, indicating by sample tag identification number, whether the sample tested negative or positive for prohibited substances. The commission chemist shall report test findings to no person other than the administrator or commission representative, with the exception of notifying the state stewards of all positive tests.

g. In the event the commission chemist should find a sample suspicious for a prohibited medication, additional time for test analysis and confirmation may be requested.

h. In reporting to the state steward a finding of a test positive for a prohibited substance, the commission chemist shall present documentary or demonstrative evidence acceptable in the scientific community and admissible in court in support of the professional opinion as to the positive finding.

i. No action shall be taken by the state steward until an official report signed by the chemist properly identifying the medication, drug, or other substance as well as the horse from which the sample was taken has been received.

j. The cost of the testing and analysis shall be paid by the commission to the official chemist. The commission shall then be reimbursed by each facility on a per-sample basis so that each facility shall bear only its proportion of the total cost of testing and analysis. The commission may first receive payment from funds provided in Iowa Code chapter 99D, if available.

9.7(4) *Practicing veterinarian.*

a. Prohibited acts.

(1) Ownership. A licensed veterinarian practicing at any meeting is prohibited from possessing any ownership, directly or indirectly, in any racing animal racing during the meeting.

(2) Wagering. Veterinarians licensed by the commission as veterinarians are prohibited from placing any wager of money or other thing of value directly or indirectly on the outcome of any race conducted at the meeting at which the veterinarian is furnishing professional service.

(3) Prohibition of furnishing injectable materials. No veterinarian shall within the facility premises furnish, sell, or loan any hypodermic syringe, needle, or other injection device, or any drug, narcotic, or prohibited substance to any other person unless with written permission of the stewards.

b. The use of other than single-use disposable syringes and infusion tubes on facility premises is prohibited. Whenever a veterinarian has used a hypodermic needle or syringe the veterinarian shall destroy the needle and syringe and remove the needle and syringe from the facility premises.

c. Veterinarians must submit daily to the commission veterinarian on a prescribed form a report of all procedures, medications and other substances which the veterinarian prescribed, administered, or dispensed for racing animals registered at the current race meeting as provided in Iowa Code section 99D.25(10). Reports shall be submitted in a manner and at a time determined by the commission veterinarian not later than noon the day following the treatments' being reported. Reports shall include the racing animal, trainer, procedure, medication or other substance, dosage or quantity, route of administration, date and time administered, dispensed, or prescribed. Reports shall be signed by the practicing veterinarian.

d. Within 20 minutes following the administration of furosemide, the veterinarian must deliver to the commission veterinarian or commission representative a signed affidavit certifying information regarding the treatment of the horse. The statement must include, at a minimum, the name of the practicing veterinarian, the tattoo number or freeze brand number of the horse, the location of the barn and stall where the treatment occurred, the race number of the horse, the name of the trainer, and the time that the furosemide was administered. This affidavit must be signed by the trainer or trainer's designee who witnessed the administration of furosemide. The veterinarian shall not administer the furosemide if a witness is not present. Furosemide shall only be administered (by a single intravenous injection) in a dose level allowed by Iowa Code section 99D.25A, subsection 7.

e. Each veterinarian shall report immediately to the commission veterinarian any illness presenting unusual or unknown symptoms in a racing animal entrusted into the veterinarian's care.

f. Practicing veterinarians may have employees licensed as veterinary assistants working under their direct supervision. Activities of these employees shall not include direct treatment or diagnosis of any animal. The practicing veterinarian must be present if a veterinary assistant is to have access to injection devices or injectables. The practicing veterinarian shall assume all responsibility for a veterinary assistant.

g. Equine dentistry is considered a function of veterinary practice by the Iowa veterinary practice Act. Any dental procedures performed at the facility must be performed by a licensed veterinarian or a licensed veterinary assistant.

h. Unless approved by the commission veterinarian, veterinarians shall not have contact with an entered horse on race day except for the administration of furosemide.

These rules are intended to implement Iowa Code chapter 99D.

[Filed emergency 5/17/85—published 6/5/85, effective 5/17/85]
[Filed emergency 10/20/86—published 11/19/86, effective 10/20/86]
[Filed 3/6/87, Notice 1/14/87—published 3/25/87, effective 4/29/87]
[Filed 10/23/87, Notice 9/9/87—published 11/18/87, effective 12/23/87]
[Filed emergency 5/13/88 after Notice 4/6/88—published 6/1/88, effective 5/13/88]
[Filed 5/13/88, Notice 4/6/88—published 6/1/88, effective 7/6/88]
[Filed 12/21/88, Notice 9/21/88—published 1/11/89, effective 2/15/89]

[Filed emergency 1/19/89—published 2/8/89, effective 1/20/89]
[Filed 3/15/89, Notice 2/8/89—published 4/6/89, effective 5/10/89]
[Filed emergency 6/23/89—published 7/12/89, effective 6/23/89]
[Filed 9/26/89, Notice 7/12/89—published 10/18/89, effective 11/22/89]
[Filed 2/16/90, Notice 12/27/89—published 3/7/90, effective 4/11/90]
[Filed 2/15/91, Notice 1/9/91—published 3/6/91, effective 4/10/91]
[Filed 6/18/99, Notice 5/5/99—published 7/14/99, effective 8/18/99]
[Filed 1/20/00, Notice 11/17/99—published 2/9/00, effective 3/15/00]
[Filed 7/20/00, Notice 6/14/00—published 8/9/00, effective 9/13/00]
[Filed 4/24/01, Notice 2/7/01—published 5/16/01, effective 6/20/01]
[Filed 9/20/01, Notice 8/8/01—published 10/17/01, effective 11/21/01]
[Filed 7/18/02, Notice 6/12/02—published 8/7/02, effective 9/11/02]
[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]
[Filed 9/7/04, Notice 7/7/04—published 9/29/04, effective 11/3/04]
[Filed 4/21/05, Notice 2/16/05—published 5/11/05, effective 6/15/05]
[Filed 4/21/06, Notice 2/15/06—published 5/10/06, effective 6/14/06]
[Filed 1/11/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
[Filed 6/6/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]

CHAPTER 11
GAMBLING GAMES

491—11.1(99F) Definitions.

"Administrator" means the administrator of the commission.

"Coin" means tokens, nickels, and quarters of legal tender.

"Commission" means the racing and gaming commission.

"Distributor's license" means a license issued by the administrator to any entity that sells, leases, or otherwise distributes gambling games to any entity licensed to conduct gambling games pursuant to Iowa Code chapter 99F.

"EPROM" means a computer chip that stores erasable, programmable, read-only memory.

"Facility" means an entity licensed by the commission to conduct gaming operations in Iowa.

"Facility grounds" means all real property utilized by the facility in the conduct of its gaming activity, including the grandstand, concession stands, offices, parking lots, and any other areas under the jurisdiction of the commission.

"Gambling game" means any game of chance approved by the commission for wagering, including, but not limited to, gambling games authorized by this chapter.

"Government sponsored enterprise debt instrument" means a negotiable, senior, noncallable debt obligation issued by an agency of the United States or an entity sponsored by an agency of the United States that on the date of funding possesses an issuer credit rating equivalent to the highest investment grade rating given by Standard & Poor's or Moody's Investment Services.

"Implement of gambling" means any device or object determined by the administrator to directly or indirectly influence the outcome of a gambling game; collect wagering information while directly connected to a slot machine; or be integral to the conduct of a commission-authorized gambling game, possession or use of which is otherwise prohibited by statute.

"Manufacturer's license" means a license issued by the administrator to any entity that assembles, fabricates, produces, or otherwise constructs a gambling game or implement of gambling used in the conduct of gambling games pursuant to Iowa Code chapter 99F.

"Qualified investment" means an Iowa state issued debt instrument, a United States Treasury debt instrument or a government sponsored enterprise debt obligation.

"Slot machine" means a mechanical or electronic gambling game device into which a player may deposit coins, currency, or other form of cashless wagering and from which certain numbers of credits are paid out when a particular configuration of symbols or events is displayed on the machine.

491—11.2(99F) Conduct of all gambling games.

11.2(1) *Commission policy.* It is the policy of the commission to require that all facilities conduct gambling games in a manner suitable to protect the public health, safety, morals, good order, and general welfare of the state. Responsibility for the employment and maintenance of suitable methods of operation rests with the facility. Willful or persistent use or toleration of methods of operation deemed unsuitable in the sole discretion of the commission will constitute grounds for disciplinary action, up to and including license revocation.

11.2(2) *Activities prohibited.* A facility is expressly prohibited from the following activities:

a. Failing to conduct advertising and public relations activities in accordance with decency, dignity, good taste, and honesty.

b. Permitting persons who are visibly intoxicated to participate in gaming activity.

c. Failing to comply with or make provision for compliance with all federal, state, and local laws and rules pertaining to the operation of a facility including payment of license fees, withholding payroll taxes, and violations of alcoholic beverage laws or regulations.

d. Possessing, or permitting to remain in or upon any facility grounds, any associated gambling equipment which may have in any manner been marked, tampered with, or otherwise placed in a condition or operated in a manner which might affect the game and its payouts.

e. Permitting, if the facility was aware of, or should have been aware of, any cheating.

f. Possessing or permitting to remain in or upon any facility grounds, if the facility was aware of, or should have been aware of, any cheating device whatsoever; or conducting, carrying on, operating, or dealing any cheating or thieving game or device on the grounds.

g. Possessing or permitting to remain in or upon any facility grounds, if the facility was aware of, or should have been aware of, any gambling device which tends to alter the normal random selection of criteria which determines the results of the game or deceives the public in any way.

h. Failing to conduct gaming operations in accordance with proper standards of custom, decorum, and decency; or permitting any type of conduct that reflects negatively on the state or acts as a detriment to the gaming industry.

i. Denying a commissioner or commission representative, upon proper and lawful demand, information or access to inspect any portion of the gaming operation.

11.2(3) *Gambling aids.* No person shall use, or possess with the intent to use, any calculator, computer, or other electronic, electrical, or mechanical device that:

a. Assists in projecting the outcome of a game.

b. Keeps track of cards that have been dealt.

c. Keeps track of changing probabilities.

11.2(4) *Wagers.* Wagers may only be made:

a. By a person present at a facility.

b. In the form of chips, coins, or other cashless wagering system.

c. By persons 21 years of age or older.

491—11.3(99F) Gambling games approved by the commission. The commission may approve a gambling game by administrative rule, resolution, or motion.

491—11.4(99F) Approval for distribution or operation of gambling games and implements of gambling.

11.4(1) *Approval.* Prior to distribution, a distributor shall request that the administrator inspect, investigate, and approve a gambling game or implement of gambling for compliance with commission rules and the standards required by a commission-designated independent testing facility. The distributor, at its own expense, must provide the administrator and independent testing facility with information and product sufficient to determine the integrity and security of the product, including independent testing conducted by a designated testing facility. The commission shall designate up to two independent testing facilities for the purpose of certifying electronic gambling games or implements of gambling.

11.4(2) *Trial period.* Prior to or after commission approval and after completing a review of a proposed gambling game, the administrator may require a trial period of up to 180 days to test the gambling game in a facility. During the trial period, minor changes in the operation or design of the gambling game may be made with prior approval of the administrator. During the trial period, a gambling game distributor shall not be entitled to receive revenue of any kind from the operation of that gambling game.

11.4(3) *Gambling game submissions.* Prior to conducting a commission-authorized gambling game or for a trial period, a facility shall submit proposals for game rules, procedures, wagers, shuffling procedures, dealing procedures, cutting procedures, and payout odds. The gambling game submission, or requests for modification to an approved submission, shall be in writing and approved by the administrator or a commission representative prior to implementation.

11.4(4) *Public notice.* The public shall have access to the rules of play, payout schedules, and permitted wagering amounts. Signage shall be conspicuously posted on the gaming floor to direct patrons to the gaming floor area where this information can be viewed. All participants in all licensed gambling games are required to know and follow the rules of play. No forms of cheating shall be permitted.

11.4(5) *Operation.* Each gambling game shall operate and play in accordance with the representation made to the commission and the public at all times. The administrator or commission representative may order the withdrawal of any gambling game suspected of malfunction or misrepresentation, until all deficiencies are corrected. The administrator or commission representative may require additional testing by an independent testing facility at the expense of the licensee or distributor for the purpose of complying with this subrule.

491—11.5(99F) Gambling games authorized.

11.5(1) Dice, craps, roulette, twenty-one (blackjack), big six—roulette, red dog, baccarat, and poker are authorized as table games.

11.5(2) Slot machines, video poker, and all other video games of chance, both progressive and nonprogressive, shall be allowed as slot machine games, subject to the administrator's approval of individual slot

machine prototypes and game variations. For racetrack enclosures without a table games license, video machines which simulate table games of chance shall not be allowed.

11.5(3) The administrator is authorized to approve variations of approved gambling games and bonus features or progressive wagers associated with approved gambling games, subject to the requirements of rule 11.4(99F).

11.5(4) Gambling games of chance involving prizes awarded to participants through promotional activities at a facility.

a. Proposals. Gambling games of chance involving prizes awarded to participants through promotional activities occurring at a facility shall be authorized and approved by the commission. Before a facility may conduct such gambling games, all proposals for terms, game rules, prizes, dates of operation and procedures for any gambling games of chance involving prizes awarded through promotional activities occurring at a facility shall be submitted in writing to a commission representative for approval. The written submission shall be submitted to the commission representative at least 14 days in advance of the planned activity. Any changes to an approved gambling game of chance involving prizes awarded to participants through promotional activities shall also require the approval of the commission representative. Gambling games of chance involving prizes awarded to participants through promotional activities occurring at a facility shall meet the following requirements:

(1) All rules of play shall be in writing and posted for public inspection;

(2) Such games shall be limited to participants 21 years of age or older;

(3) All games shall be conducted in a fair and honest manner, and all prizes advertised shall be awarded in accordance with the posted rules of play;

(4) All such games shall be conducted within the regulated area of the facility and shall be conducted in accordance with the submission approved by the commission representative;

(5) No entry fees shall be permitted; and

(6) All employees of the facility shall be prohibited from participation.

b. Limits. Gambling games of chance involving prizes awarded to participants through promotional activities conducted at a facility shall be subject to the wagering tax pursuant to Iowa Code section 99F.11. However, in determining the adjusted gross receipts, the facility may consider all nonmonetary consideration expended by a participant and shall certify to the commission that the nonmonetary consideration is at least equal to the value of the prizes awarded.

491—11.6(99F) Gambling game-based tournaments.

11.6(1) *Proposals.* Proposals for terms, game rules, entry fees, prizes, dates, and procedures must be submitted in writing and approved by a commission representative before a facility conducts any tournament. Any changes to approved tournaments must be submitted to the commission representative for review and approval prior to being implemented. Rules, fees, and a schedule of prizes must be made available to the player prior to entry.

11.6(2) *Limits.* Tournaments must be based on gambling games authorized by the commission. Entry fees, less prizes paid, are subject to the wagering tax pursuant to Iowa Code section 99F.11. In determining adjusted gross receipts, to the extent that prizes paid out exceed entry fees received, the facility shall be deemed to have paid the fees for the participants.

491—11.7(99F) Table game requirements.

11.7(1) Removable storage media in a table game device which controls the randomness of card shufflers or progressive table game meters shall be verified and sealed with evidence tape by a commission representative prior to implementation.

11.7(2) Wagers. All wagers at table games shall be made by placing gaming chips or coins on the appropriate areas of the layout.

11.7(3) Craps. Wagers must be made before the dice are thrown. "Call bets," or the calling out of bets between the time the dice leave the shooter's hand and the time the dice come to rest, not accompanied by the placement of gaming chips, are not allowed.

11.7(4) Twenty-one.

a. Before the first card is dealt for each round of play, each player shall make a wager against the dealer. Once the first card of any hand has been dealt by the dealer, no player shall handle, remove, or alter any wagers that have been made until a decision has been rendered and implemented with respect to that wager. Once a wager on the insurance line, a wager to double down, or a wager to split pairs has been made and confirmed by the dealer, no

player shall handle, remove, or alter the wagers until a decision has been rendered and implemented with respect to that wager, except as explicitly permitted. A facility or licensee shall not permit any player to engage in conduct that violates this paragraph.

b. At the conclusion of a round of play, all cards still remaining on the layout shall be picked up by the dealer in a prescribed order and in such a way that they can be readily arranged to indicate each player's hand in case of question or dispute. The dealer shall pick up the cards beginning with those of the player to the far right and moving counterclockwise around the table. The dealer's hand will be the last hand collected. The cards will then be placed on top of the discard pile. No player or spectator shall remove or alter any cards used to game at twenty-one or be permitted to do so by a casino employee.

c. Each player at the table shall be responsible for correctly computing the point count of the player's hand. No player shall rely on the point counts announced by the dealer without checking the accuracy of such announcement.

11.7(5) Roulette.

a. No person at a roulette table shall be issued or permitted to game with nonvalue gaming chips that are identical in color and design to value gaming chips or to nonvalue gaming chips being used by another person at that same table.

b. Each player shall be responsible for the correct positioning of the player's wager on the roulette layout, regardless of whether the player is assisted by the dealer. Each player must ensure that any instructions the player gives to the dealer regarding the placement of the player's wager are correctly carried out.

c. Each wager shall be settled strictly in accordance with its position on the layout when the ball falls to rest in a compartment of the wheel.

11.7(6) Big six—roulette.

a. Each player shall be responsible for the correct positioning of the player's wager on the layout regardless of whether the player is assisted by the dealer.

b. Each wager shall be settled strictly in accordance with its position on the layout when the wheel stops with the winning indicator in a compartment of the wheel.

11.7(7) Poker.

a. When a facility conducts poker with an impress dealer gaming chip bank, the rules in 491—Chapter 12 for closing and distributing or removing gaming chips to or from gaming tables do not apply. The entire amount of the table rake is subject to the wagering tax pursuant to Iowa Code section 99F.11. Proposals for impress dealer gaming chip banks must be submitted in writing and approved by a commission representative prior to use.

b. All games shall be played according to table stakes game rules as follows:

(1) Only gaming chips or coins on the table at the start of a deal shall be in play for that pot.

(2) Concealed gaming chips or coins shall not play.

(3) A player with gaming chips may add additional gaming chips between deals, provided that the player complies with any minimum buy-in requirement.

(4) A player is never obliged to drop out of contention because of insufficient gaming chips to call the full amount of a bet, but may call for the amount of gaming chips the player has on the table. The excess part of the bet made by other players is either returned to the players or used to form a side pot.

c. Each player in a poker game is required to act only in the player's own best interest. The facility has the responsibility of ensuring that any behavior designed to assist one player over another is prohibited. The facility may prohibit any two players from playing in the same game.

d. Poker games where winning wagers are paid by the facility according to specific payout odds or pay tables are permitted.

11.7(8) Red dog. Before the first card is dealt for each round of play, each player shall make a wager against the dealer. Once the first card of any hand has been dealt by the dealer, no player shall handle, remove, or alter any wagers that have been made until a decision has been rendered and implemented with respect to that wager. Once a wager to double down has been made and confirmed by the dealer, no player shall handle, remove, or alter the wagers until a decision has been rendered and implemented with respect to that wager, except as explicitly permitted.

491—11.8(99F) Keno.

11.8(1) Keno shall be conducted using an automated ticket writing and redemption system where a game's winning numbers are selected by a random number generator.

11.8(2) Each game shall consist of the selection of 20 numbers out of 80 possible numbers, 1 through 80.

11.8(3) For any type of wager offered, the payout must be at least 80 percent.

11.8(4) Multigame tickets shall be limited to 20 games.

11.8(5) Writing or voiding tickets for a game after that game has closed is prohibited.

11.8(6) All winning tickets shall be valid up to a maximum of one year from the date of purchase. The dollar value of all expired and unclaimed winning tickets shall be added to existing keno jackpots in a manner approved by the administrator.

11.8(7) The administrator shall determine minimum hardware and software requirements to ensure the integrity of play. An automated keno system must be proven to accurately account for adjusted gross receipts to the satisfaction of the administrator.

11.8(8) Adjusted gross receipts from keno games shall be the difference between dollar value of tickets written and dollar value of winning tickets as determined from the automated keno system. The wagering tax pursuant to Iowa Code section 99F.11 shall apply to adjusted gross receipts of keno games.

491—11.9(99F) Slot machine requirements.

11.9(1) Movement.

a. Any entity providing slot machines, gambling games, or implements of gambling to a licensed facility must file written notice with the commission at least five calendar days prior to receipt by the facility. A licensed facility selling or an owner removing slot machines, gambling games, or implements of gambling from the facility must file written notice with the commission at least one day prior to removal. Notification by facsimile or E-mail shall be considered written notice.

b. The administrator may approve licensee transfers of slot machines, gambling games, or implements of gambling among subsidiaries of the licensee's parent company.

11.9(2) Payout percentage. A slot machine game must meet the following maximum and minimum theoretical percentage payouts during the expected lifetime of the game.

a. A slot machine game's theoretical payout must be at least 80 percent and no more than 100 percent of the amount wagered. The theoretical payout percentage is determined using standard methods of probability theory.

b. A slot machine game shall have a probability of obtaining the highest single advertised payout, which must statistically occur at least once in 50,000,000 games.

11.9(3) Unless otherwise authorized by the administrator, each slot machine in a casino shall have the following identifying features:

a. A manufacturer's serial number that is firmly attached and visible.

b. A casino number at least two inches in height permanently imprinted, affixed, or impressed on the outside of the machine so that the number may be observed by the surveillance camera.

c. A display located conspicuously on the slot machine that automatically illuminates when a player has won a jackpot not paid automatically and totally by the slot machine and which advises the player to see an attendant to receive full payment.

d. A display on the front of the slot machine that clearly represents its rules of play, character combinations requiring payouts, and the amount of the related payouts. In addition, a facility shall display on the slot machine a clear description of any merchandise or thing of value offered as a payout including the cash equivalent value of the merchandise or thing of value offered, the dates the merchandise or thing of value will be offered if the facility establishes a time limit upon initially offering the merchandise or thing of value, and the availability or unavailability to the patron of the optional cash equivalent value. A cash equivalent value shall be at least 75 percent of the fair market value of the merchandise or thing of value offered.

e. A mechanical, electrical, or electronic device that automatically precludes a player from operating the slot machine after winning a jackpot requiring a manual payout. The device must require an attendant to reactivate the machine.

f. A light on the pedestal above the slot machine that automatically illuminates when the door to the slot machine or any device connected which may affect the operation of the slot machine is opened.

g. Test connections as may be specified and approved by the administrator for the on-site inspection, examination, and testing of the machine.

h. Devices, equipment, features, and capabilities, as may be required by the commission, that are specific to that slot machine after the prototype model is approved by the commission.

11.9(4) Storage media. Hardware media devices which contain game functions or characteristics, including but not limited to pay tables and random number generators, shall be verified and sealed with evidence tape by a commission representative prior to being placed in operation, as determined by the administrator.

11.9(5) Posting of the actual aggregate payout percentage. The actual aggregate payout percentage to the nearest one-tenth (0.1) percent of all slot machine games in operation during the preceding three calendar months shall be posted at the main casino entrance, cashier cages, and slot booths by the fifteenth day of each calendar month. For the purpose of this calculation, the actual aggregate payout percentage shall be the slot revenue reported to the commission during the preceding three calendar months divided by the slot coin-in reported to the commission during the preceding three calendar months subtracted from 100 percent.

491—11.10(99F) Slot machine hardware and software requirements.

11.10(1) *Hardware specifications.*

a. Electrical and mechanical parts and design principles shall not subject a player to physical hazards.

b. A surge protector must be installed on the line that feeds power to a slot machine. The battery backup, or an equivalent, for the electronic meters must be capable of maintaining accuracy of all information required for 180 days after power is discontinued from a slot machine. The backup shall be kept within the locked logic board compartment.

c. An on/off switch that controls the electrical current used in the operation of a slot machine and any associated equipment must be located in an accessible place within the interior of the slot machine.

d. The operation of each slot machine must not be adversely affected by static discharge or other electromagnetic interference.

e. A minimum of one electronic coin acceptor must be installed in each slot machine with the exception of coinless or coin-free games. Coinless or coin-free games are defined as slot machines that do not have a hopper mechanism and do not utilize coin in the operation of the game. Approval letters and test reports of electronic coin acceptors from other state or federal jurisdictions may be submitted. However, all coin acceptors are subject to approval by the administrator.

f. The internal space of a slot machine shall not be readily accessible when the front door is both closed and locked.

g. Logic boards and software EPROMs must be in a locked compartment within the slot machine.

h. The drop container must be in a locked compartment within or attached to the slot machine.

i. No hardware switches may be installed that alter the pay tables or payout percentages in the operation of a slot machine. Hardware switches may be installed to control graphic routines, speed of play, and sound.

j. An unremovable identification plate must appear on the exterior of the slot machine that contains the following information:

(1) Manufacturer.

(2) Serial number.

(3) Model number.

k. The rules of play for each slot machine must be displayed on the face or screen. Rules may be rejected if they are incomplete, confusing, or misleading. Each slot machine must also display the credits wagered and the credits awarded for the occurrence of each possible winning combination based on the number of credits wagered. All information required by this subrule shall be kept under glass or another transparent surface and at no time may stickers or other removable items be placed on the slot machine face that make the required information unreadable.

l. Equipment must be installed that enables the machine to communicate with a central computer system accessible to commission representatives using a communications protocol provided to each licensed manufacturer by the commission for the information and control programs approved by the administrator.

11.10(2) *Software requirements—random number generator.* Each slot machine must have a random number generator to determine the results of the game symbol selections or production of game outcomes. The selection shall:

a. Be statistically independent.

b. Conform to the desired random distribution.

c. Pass various recognized statistical tests.

d. Be unpredictable.

e. Have a testing confidence level of 95 percent.

11.10(3) *Continuation of game after malfunction is cleared.* Each slot machine must be capable of continuing the current game with all current game features after a malfunction is cleared. This rule does not apply if a slot machine is rendered totally inoperable; however, the current wager and all credits appearing on the screen prior to the malfunction must be returned to the player.

11.10(4) *Software requirements—play transaction records.* Each slot machine must maintain electronic accounting meters at all times, regardless of whether the slot machine is being supplied with power. Each meter must be capable of maintaining totals no fewer than six digits in length for the information required in *"a"* to *"d"* below. The electronic meters must record the following:

a. Total number of coins inserted.
b. Total number of coins paid out.
c. Total number of coins dropped to drop container.
d. Total number of credits wagered.
e. Total number of credits won.
f. Total number of credits paid out.
g. Number of times the logic area was accessed.
h. Number of times the cash door of the device was accessed.
i. Number of coins or credits wagered in the current game.
j. Total credits for games won but not collected, commonly referred to as the credit meter.

The meters required in *"a," "b,"* and *"c"* above shall be placed in a position so that the number thereon can be read without opening the slot machine.

No slot machine may have a mechanism that will cause the electronic accounting meters to automatically clear due to an error. Clearing of the electronic accounting meters may be completed only after notification is filed with a commission representative. All meter readings must be recorded both before and after the electronic accounting meter is cleared.

11.10(5) *Software requirements—error conditions—automatic clearing.* Slot machines must be capable of detecting and displaying the following conditions, which must be automatically cleared by the slot machine upon initiation of a new play sequence at the start of the second game.

a. Power reset.
b. Door open.

491—11.11(99F) Slot machine specifications.

11.11(1) *Error conditions.*

a. Slot machines must be capable of detecting and displaying the following error conditions which are manually cleared:

(1) Coin-in jam.
(2) Coin-out jam.
(3) Hopper empty or timed out.
(4) RAM error.
(5) Hopper runaway or extra coins paid out.
(6) Low RAM battery, for batteries external to the RAM itself. A battery approved by a commission representative that is replaced pursuant to its manufacturer's specifications or as specified in the prototype approval report, whichever is sooner, may be installed in lieu of the low RAM battery error condition.

b. A description of slot machine error codes and each code's meaning must be affixed inside the slot machine.

11.11(2) *Hopper mechanism.* Slot machines equipped with a hopper must be designed to detect jammed coins, extra coins paid out, hopper runaways, and hopper empty conditions. The slot machine control program must monitor the hopper mechanism for these error conditions in all game states. All coins paid from the hopper mechanism must be accounted for by the slot machine, including those paid as extra coins during a hopper malfunction.

491—11.12(99F) Progressive slot machines.

11.12(1) *Meter required.* A progressive machine is a slot machine game with an award amount that increases based on a function of credits bet on the slot machine. A progressive slot machine or group of linked progressive slot machines must have a meter showing the progressive jackpot payout.

11.12(2) *Progressive controllers.* The reset or base value and the rate of increment of a progressive jackpot game must be filed with a commission representative prior to implementation. A reset or base value must equal or exceed the equivalent nonprogressive jackpot payout.

11.12(3) *Limits.* A facility may impose a limit on the progressive jackpot payout of a slot machine if the limit imposed is greater than the progressive jackpot payout at the time the limit is imposed. The facility must prominently display a notice informing the public of the limit. No progressive meter may be turned back to a lesser amount unless one of the following circumstances occurs:

a. The amount shown on the progressive meter is paid to a player as a jackpot.

b. It is necessary to adjust the progressive meter to prevent it from displaying an amount greater than the limit imposed by the facility.

c. It is necessary to change the progressive indicator because of game malfunction.

11.12(4) *Transfer of jackpots.* In the event of malfunction, replacement, or other reason approved by the commission, a progressive jackpot that is removed shall be transferred to another progressive slot machine at the same facility within 30 days from the removal date. A commission representative shall be notified in writing prior to a removal or transfer.

11.12(5) *Records required.* Records must be maintained that record the amount shown on a progressive jackpot meter. Supporting documents must be maintained to explain any reduction in the payoff amount from a previous entry. The records and documents must be retained for a period of three years unless permission to destroy them earlier is given in writing by the administrator.

11.12(6) *Transfer of progressive slot machines.* A progressive slot machine, upon permission of the administrator, may be moved to a different facility if a bankruptcy, loss of license, or other good cause warrants.

11.12(7) *Linked machines.* Each machine on the link shall have the same probability of winning the progressive jackpot, adjusted for the total amount wagered. The product of the odds of winning the progressive jackpot multiplied by the maximum amount wagered shall be equal for all games on the link.

11.12(8) *Wide area progressive systems.* A wide area progressive system is a method of linking progressive slot machines or electronic gaming machines across telecommunication lines as part of a network connecting participating facilities. The purpose of a wide area progressive system is to offer a common progressive jackpot (system jackpot) at all participating locations. The operation of a wide area progressive system (multilink) is permitted subject to the following conditions:

a. The method of communication over the multilink must consist of dedicated on-line communication lines (direct connect), dial-tone lines, or wireless communication which may be subject to certain restrictions imposed by the administrator.

b. All communication between each facility location and the central system site must be encrypted.

c. All meter reading data must be obtained in real time in an on-line automated fashion. When requested to do so, the system must return meter readings on all slot machines or electronic gaming machines attached to the multilink within a reasonable time of the meter acquisition request. Manual reading of meter values may not be substituted for these requirements. There is no restriction as to the acceptable method of obtaining meter reading values, provided that the methods consist of either pulses from any machine computer board or associated wiring, or the use of serial interface to the machine's random access memory (RAM) or other nonvolatile memory.

d. The multilink must have the ability to monitor entry into the front door of the machine as well as the logic area of the machine and report such data to a central system.

e. The central system site must be located in the state of Iowa, be equipped with a noninterruptible power supply, and the central computer must be capable of on-line data redundancy should hard disk peripherals fail during operation. The office containing the central computer shall be equipped with a surveillance system that has been approved by the administrator. Any person authorized to provide a multilink shall be required to keep and maintain an entry and exit log for the office containing the central computer. Any person authorized to provide a multilink shall provide access to the office containing the central computer to the administrator and shall make available to the administrator all books, records, and information required by the administrator in fulfilling its regulatory purpose.

f. Any person authorized to provide a multilink must suspend play on the multilink if a communication failure of the system cannot be corrected within 24 consecutive hours.

g. Approval by a commission representative of any multilink shall occur only after the administrator has reviewed the multilink software and hardware and is satisfied that the operation of the system meets accepted

industry standards for multilink products, as well as any other requirements that the administrator may impose to ensure the integrity, security, and legal operation of the multilink.

h. A meter that shows the amount of the system jackpot must be conspicuously displayed at or near the machines to which the jackpot applies. The system jackpot meter need not precisely show the actual moneys in the system jackpot award at each instant. Nothing shall prohibit the use of odometer or other paced updating progressive displays. In the case of the use of paced updating displays, the system jackpot meter must display the winning value after the jackpot broadcast is received from the central system, providing the remote site is communicating to the central computer. If a system jackpot is recognized in the middle of a systemwide poll cycle, the system jackpot display may contain a value less than the aggregated amount calculated by the central system. The coin values from the remaining portion of the poll cycle will be received by the central system but not the local site, in which case the system jackpot amount paid will always be the higher of the two reporting amounts.

i. When a system jackpot is won, a person authorized to provide the multilink and the trustee(s) provided for in paragraph *"n,"* subparagraph (1), shall have the opportunity to inspect the machine, EPROM, the error events received by the central system, and any other data which could reasonably be used to ascertain the validity of the jackpot.

(1) The central system shall produce reports that will clearly demonstrate the method of arriving at the payoff amount. This shall include the coins contributed beginning with the polling cycle immediately following the previous jackpot and will include all coins contributed up to, and including, the polling cycle, which includes the jackpot signal. Coins contributed to and registered by the system before the jackpot message is received will be deemed to have been contributed to the progressive amount prior to the current jackpot. Coins contributed to the system subsequent to the jackpot message's being received as well as coins contributed to the system before the jackpot message is received by the system, but registered after the jackpot message is received at the system, will be deemed to have been contributed to the progressive amount of the next jackpot.

(2) The system jackpot may be disbursed in periodic payments as long as each machine clearly displays the fact that the jackpot will be paid in such periodic payments. In addition, the number of periodic payments and time between payments must be clearly displayed on the face of the slot machine in a nonmisleading manner.

(3) Two system jackpots which occur in the same polling cycle before the progressive amount can reset will be deemed to have occurred simultaneously; therefore, each winner shall receive the full amount shown on the system jackpot meter.

j. Any person authorized to provide a multilink must supply to the commission and the trustee(s), as requested, reports which support and verify the economic activity of the system.

(1) Any person authorized to provide a multilink must supply to the commission and the trustee(s), as requested, reports and information indicating the amount of, and basis for, the current system jackpot amount. Such reports may include an aggregate report and a detail report. The aggregate report may show only the balancing of the system with regard to systemwide totals. The detail report shall be in such form as to indicate for each machine, summarized by location, the coin-in totals as such terms are commonly understood in the industry.

(2) In addition, upon the invoicing of any facility participating in a multilink, each such facility must be given a printout of each machine operated by that facility, the coins contributed by each machine to the system jackpot for the period for which an invoice is remitted, and any other information required by the commission to confirm the validity of the facility's contributions to the system jackpot.

k. In calculating adjusted gross receipts, a facility may deduct its pro-rata share of the present value of any system jackpots awarded. Such deduction shall be listed on the detailed accounting records provided by the person authorized to provide the multilink. A facility's pro-rata share is based on the number of coins in from that facility's machines on the multilink, compared to the total amount of coins in on the whole system for the time period(s) between jackpot(s) awarded.

l. In the event a facility ceases operations and a progressive jackpot is awarded subsequent to the last day of the final month of operation, the facility may not file an amended wagering tax submission or make a claim for a wagering tax refund based on its contributions to that particular progressive prize pool.

m. A facility, or an entity that is licensed as a manufacturer or distributor, shall provide the multilink, in accordance with a written agreement which shall be reviewed and approved by the commission prior to offering the jackpots. A trust maintained by the participating facilities shall be established to control the system jackpot fund (trust fund) provided for in paragraph *"n,"* subparagraph (3).

n. The payment of any system jackpot offered on a multilink shall be administered by the trustee(s) in accordance with a written trust agreement which shall be reviewed and approved by the commission prior to the offering of the jackpot. The trustee(s) may contract with a licensed manufacturer or distributor to administer the trust fund. The trust agreement shall require the following:

(1) Any facility participating in offering the system jackpot shall serve as trustee for the trust fund.

(2) Any facility shall be jointly and severally liable for the payment of system jackpots won on a multilink in which the licensee is or was a participant at the time the jackpot was won.

(3) The moneys in the trust fund shall consist of the sum of funds invoiced to the facilities and received by the trust from the facilities with respect to each particular system, which invoices shall be based on a designated percentage of the handle generated by all machines linked to the particular system; any income earned by the trust; and sums borrowed by the trust and any other property received by the trust. Prior to the payment of any other expenses, the trust funds shall be used to purchase a qualified investment in sufficient amounts to ensure that the trust will have adequate moneys available in each year to make all system jackpot payments which are required under the terms of the multilink.

(4) A reserve shall be established and maintained within the trust fund sufficient to purchase any qualified investment required as system jackpots are won (systems reserves). For purposes of this rule, the system reserves shall mean an amount equal to the sum of the present value of the aggregate remaining balances owed on all jackpots previously won by patrons on the multilink; the present value of the amount currently reflected on the system jackpot meters of the multilink; and the present value of one additional reset (start amount) on such systems.

(5) The trust shall continue to be maintained until all payments owed to winners of the system jackpots have been made.

(6) For system jackpots disbursed in periodic payments, any qualified investment shall be purchased within 90 days following notice of the win of the system jackpot, and a copy of such qualified investment will be provided to the commission office within 30 days of purchase. Any qualified investment shall have a surrender value at maturity, excluding any interest paid before the maturity date, equal to or greater than the value of the corresponding periodic jackpot payment, and shall have a maturity date prior to the date the periodic jackpot payment is required to be made.

(7) The trustee(s) shall not be permitted to sell, trade, or otherwise dispose of any qualified investments prior to maturity unless approval to do so is first obtained from the commission.

(8) Upon becoming aware of an event of noncompliance with the terms of the approved trust agreement or reserve requirement mandated by subparagraph (4) above, the trustee(s) must immediately notify the commission of such event. An event of noncompliance includes a nonpayment of a jackpot periodic payment or a circumstance which may cause the trustee(s) to be unable to fulfill, or otherwise impair, its ability to satisfy its jackpot payment obligations.

(9) With the exception of the transfer to the estate or heir(s) of a deceased system jackpot winner, or to the estate or heir(s) of such transferee upon death, or the granting of a first priority lien to the trust to secure repayment of a tax loan to the winner should a tax liability on the full amount of the jackpot be assessed by the Internal Revenue Service against the winner, no interest in income or principal shall be alienated, encumbered, or otherwise transferred or disposed of in any way by any person while in the possession and control of the trust.

(10) On a quarterly basis, the trustee(s) must deliver to the commission office a calculation of system reserves required under subparagraph (4) above.

(11) The trust must be audited, in accordance with generally accepted auditing standards, on the fiscal year of the trust by an independent certified public accountant. Two copies of the report must be submitted to the commission office within 90 days after the conclusion of the trust's fiscal year.

o. For system jackpots disbursed in periodic payments, subsequent to the date of the win, a winner may be offered the option to receive, in lieu of periodic payments, a discounted single cash payment in the form of a "qualified prize option," as that term is defined in Section 451(h) of the Internal Revenue Code. The trust administrator shall calculate the single cash payment based on the discount rate. "Discount rate" means either the current prime rate as published in the Wall Street Journal or a blended rate computed by obtaining quotes for the purchase of qualified investments at least three times per month. The discount rate selected by the trust administrator shall be used to calculate the single cash payment for all qualified prizes that occur subsequent to the date of the selected discount rate, until a new discount rate becomes effective.

491—11.13(99F) Licensing of manufacturers and distributors of gambling games or implements of gambling.

11.13(1) *Impact on gambling.* In considering whether a manufacturer or distributor applicant will be licensed or a specific product will be distributed, the administrator shall give due consideration to the economic impact of the applicant's product, the willingness of a licensed facility to offer the product to the public, and whether its revenue potential warrants the investigative time and effort required to maintain effective control over the product.

11.13(2) *Licensing standards.* Standards which shall be considered when determining the qualifications of an applicant shall include, but are not limited to, financial stability; business ability and experience; good character and reputation of the applicant as well as all directors, officers, partners, and employees; integrity of financial backers; and any effect on the Iowa economy.

11.13(3) *Application procedure.* Application for a manufacturer's or a distributor's license shall be made to the commission for approval by the administrator. In addition to the application, the following must be completed and presented when the application is filed:

a. Disclosure of ownership interest, directors, or officers of licensees.

(1) An applicant or licensee shall notify the administrator of the identity of each director, corporate officer, owner, partner, joint venture participant, trustee, or any other person who has any beneficial interest of 5 percent or more, direct or indirect, in the business entity. For any of the above, as required by the administrator, the applicant or licensee shall submit background information on forms supplied by the division of criminal investigation and any other information the administrator may require.

For purposes of this rule, beneficial interest includes all direct and indirect forms of ownership or control, voting power, or investment power held through any contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise.

(2) For ownership interests of less than 5 percent, the administrator may request a list of these interests. The list shall include names, percentages owned, addresses, social security numbers, and dates of birth. The administrator may request the same information required of those individuals in subparagraph (1) above.

b. Investigative fees.

(1) Advance payment. The department of public safety may request payment of the investigative fee in advance as a condition to beginning investigation.

(2) Payment required. The administrator may withhold final action with respect to any application until all investigative fees have been paid in full.

c. A bank or cashier's check made payable to the Iowa Racing and Gaming Commission for the annual license fee as follows:

(1) A manufacturer's license shall be $250.

(2) A distributor's license shall be $1,000.

d. A copy of each of the following:

(1) Articles of incorporation and certificate of incorporation, if the business entity is a corporation.

(2) Partnership agreement, if the business entity is a partnership.

(3) Trust agreement, if the business entity is a trust.

(4) Joint venture agreement, if the business entity is a joint venture.

(5) List of employees of the aforementioned who may have contact with persons within the state of Iowa.

e. A copy of each of the following types of proposed distribution agreements, where applicable:

(1) Purchase agreement(s).

(2) Lease agreement(s).

(3) Bill(s) of sale.

(4) Participation agreement(s).

f. Supplementary information. Each applicant shall promptly furnish the administrator with all additional information pertaining to the application or the applicant which the administrator may require. Failure to supply the information requested within five days after the request has been received by the applicant shall constitute grounds for delaying consideration of the application.

g. Any and all changes in the applicant's legal structure, directors, officers, or the respective ownership interests must be promptly filed with the administrator.

h. The administrator may deny, suspend, or revoke the license of an applicant or licensee in which a director, corporate officer, or holder of a beneficial interest includes or involves any person or entity which would

be, or is, ineligible in any respect, such as through want of character, moral fitness, financial responsibility, professional qualifications, or due to failure to meet other criteria employed by the administrator, to participate in gaming regardless of the percentage of ownership interest involved. The administrator may order the ineligible person or entity to terminate all relationships with the licensee or applicant, including divestiture of any ownership interest or beneficial interest at acquisition cost.

i. Disclosure. Disclosure of the full nature and extent of all beneficial interests may be requested by the administrator and shall include the names of individuals and entities, the nature of their relationships, and the exact nature of their beneficial interest.

j. Public disclosure. Disclosure is made for the benefit of the public, and all documents pertaining to the ownership filed with the administrator shall be available for public inspection.

11.13(4) *Temporary license certificates.*

a. A temporary license certificate may be issued at the discretion of the administrator.

b. Temporary licenses—period valid. Any certificate issued at the discretion of the administrator shall be valid for a maximum of 120 calendar days from the date of issue.

Failure to obtain a permanent license within the designated time may result in revocation of the license eligibility, fine, or suspension.

11.13(5) *Withdrawal of application.* A written notice of withdrawal of application may be filed by an applicant at any time prior to final action. No application shall be permitted to be withdrawn unless the administrator determines the withdrawal to be in the public interest. No fee or other payment relating to any application shall become refundable by reason of withdrawal of the application.

11.13(6) *Record keeping.*

a. Record storage required. Distributors and manufacturers shall maintain adequate records of business operations, which shall be made available to the administrator upon request. These records shall include:

(1) All correspondence with the administrator and other governmental agencies on the local, state, and federal level.

(2) All correspondence between the licensee and any of its customers who are applicants or licensees under Iowa Code chapter 99F.

(3) A personnel file on each employee of the licensee, including sales representatives.

(4) Financial records of all transactions with facilities and all other licensees under these regulations.

b. Record retention. The records listed in 11.13(6)*"a"* shall be retained as required by 491—subrule 5.4(14).

11.13(7) *Violation of laws or regulations.* Violation of any provision of any laws of the state or of the United States of America or of any rules of the commission may constitute an unsuitable method of operation, subjecting the licensee to limiting, conditioning, restricting, revoking or suspending the license, or fining the licensee, or any combination of the above.

11.13(8) *Consent to inspections, searches, and seizures.* Each manufacturer or distributor licensed under this chapter shall consent to inspections, searches, and seizures deemed necessary by the administrator and authorized by law in order to enforce licensing requirements.

These rules are intended to implement Iowa Code chapter 99F.

[Filed 10/13/00, Notice 9/6/00—published 11/1/00, effective 12/6/00]
[Filed 4/24/01, Notice 2/7/01—published 5/16/01, effective 6/20/01]
[Filed 5/17/02, Notice 4/3/02—published 6/12/02, effective 7/17/02]
[Filed 7/18/02, Notice 6/12/02—published 8/7/02, effective 9/11/02]
[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]
[Filed 9/7/04, Notice 7/7/04—published 9/29/04, effective 11/3/04]
[Filed 4/21/06, Notice 2/15/06—published 5/10/06, effective 6/14/06]
[Filed 4/20/07, Notice 2/14/07—published 5/9/07, effective 6/13/07]
[Filed 1/11/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
[Filed 6/6/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]

CHAPTER 12
ACCOUNTING AND CASH CONTROL

491—12.1(99F) Definitions.

"Casino" means all areas of a facility where gaming is conducted.

"Coin" means tokens, nickels, and quarters of legal tender.

"Commission" means the racing and gaming commission.

"Container" means:

1. A box attached to a gaming table in which shall be deposited all currency in exchange for gaming chips, fill and credit slips, requests for fill forms, and table inventory forms.

2. A canister in a slot machine cabinet to which coins played are diverted when the hopper is filled or in which currency is retained by slot machines and not used to make change or automatic jackpot payouts.

"Count room" means an area in the facility where contents of containers are counted and recorded.

"Currency" means paper money of legal tender or paper form of cashless wagering.

"Drop" means removing the containers from the casino to the count room.

"Facility" means an entity licensed by the commission to conduct gaming operations in Iowa.

"Hopper" means a payout reserve container in which coins are retained by a slot machine to automatically pay jackpots.

"Internal controls" means the facility's system of internal controls.

"Moneys" means coin and currency.

"Request" means a request for credit slip, request for fill slip, or request for jackpot payout slip.

"Slip" means a credit slip, fill slip, or jackpot payout slip.

"Slot machine" means a mechanical or electronic gambling game device into which a player may deposit coins, currency, or other form of cashless wagering and from which certain numbers of credits are paid out when a particular configuration of symbols or events is displayed on the machine.

491—12.2(99F) Accounting records.

12.2(1) Each facility shall maintain complete and accurate records of all transactions pertaining to revenues and costs.

12.2(2) General accounting records shall be maintained on a double entry system of accounting with transactions recorded on an accrual basis.

12.2(3) Detailed, supporting, and subsidiary records shall be maintained. The records shall include, but are not limited to:

a. Statistical game records by gaming day to reflect drop and win amounts by table for each game.

b. Records of all investments, advances, loans, and receivable balances due the facility.

c. Records related to investments in property and equipment.

d. Records which identify the handle, payout, win amounts and percentages, theoretical win amounts and percentages, and differences between theoretical and actual win amounts and percentages for each slot machine on a week-to-date, month-to-date, and year-to-date basis.

e. Records of all loans and other amounts payable by the facility.

f. Records that identify the purchase, receipt, and destruction of gaming chips and tokens.

12.2(4) Whenever duplicate or triplicate copies of a form, record, or document are required by these rules, the original, duplicate, and triplicate copies shall be color-coded and have the destination of the original copy identified on the duplicate and triplicate copies.

12.2(5) Whenever forms or serial numbers are required to be accounted for or copies of forms are required to be compared for agreement and exceptions are noted, such exceptions shall be reported immediately and in writing to the commission.

491—12.3(99F) Facility internal controls.

12.3(1) Each facility shall submit a description of internal controls to the commission. The submission shall be made at least 90 days before gaming operations are to commence unless otherwise directed by the administrator. The submission shall include and provide for the following:

a. Administrative control that includes, but is not limited to, the plan of organization and the procedures and records that are concerned with the decision processes leading to management's levels of authorization of transactions.

b. Accounting control that includes the plan of organization and the procedures and records that are concerned with the safeguarding of assets and the reliability of financial records. The accounting control shall be designed to provide reasonable assurance that:

(1) Transactions are executed in accordance with management's general and specific authorization, which shall be consistent with the requirements of this chapter.

(2) Transactions are recorded as necessary to permit preparation of financial statements in conformity with generally accepted accounting principles and to maintain accountability for assets.

(3) Access to assets is permitted only in accordance with management authorization, which shall be consistent with requirements of this chapter.

(4) The recorded accountability for assets is compared with existing assets at reasonable intervals and appropriate action is taken with respect to any differences.

c. Competent personnel with integrity and an understanding of prescribed internal controls.

d. The segregation of incompatible functions so that no employee is in a position to perpetrate and conceal errors or irregularities in the normal course of the employee's duties.

12.3(2) A commission representative shall review each submission required by subrule 12.3(1) and determine whether it conforms to the requirements of Iowa Code chapter 99F and is consistent with the intent of this chapter and whether the internal controls submitted provide adequate and effective control for the operations of the facility. If the commission representative finds any insufficiencies, the insufficiencies shall be specified in writing to the facility, which shall make appropriate alterations. No facility shall commence gaming operations unless and until the internal controls are approved.

12.3(3) Each facility shall submit to the commission any changes to the internal controls previously approved at least 15 days before the changes are to become effective unless otherwise directed by a commission representative. The proposed changes shall be submitted to the commission and the changes may be approved or disapproved by the commission representative. No facility shall alter its internal controls until the changes are approved.

12.3(4) It shall be the affirmative responsibility and continuing duty of each occupational licensee to follow and comply with all internal controls.

491—12.4(99F) Accounting controls within the cashier's cage.

12.4(1) The assets for which the cashiers are responsible shall be maintained on an impress basis. At the end of each shift, the cashiers assigned to the outgoing shift shall record on a cashier's count sheet the face value of each cage inventory item counted and the total of the opening and closing cage inventories and shall reconcile the total closing inventory with the total opening inventory.

12.4(2) At the conclusion of gaming activity each gaming day, a copy of the cashiers' count sheets and related documentation shall be forwarded to the accounting department for agreement of opening and closing inventories, agreement of amounts thereon to other forms, records, and documents required by this chapter, and the recording of all transactions.

12.4(3) Each facility shall place on file with the commission the names of all persons authorized to enter the cashier's cage, persons who possess the combination or keys to the locks securing the entrance to the cage, and persons who possess the ability to operate alarm systems.

491—12.5(99F) Gaming table container. Each gaming table in a casino shall have attached to it a container.

12.5(1) Each container shall have:

a. A lock securing the contents of the container, the key to which shall be checked out by the drop team.

b. A separate lock securing the container to the gaming table, the key to which shall be different from each of the keys to locks securing the contents of the container.

c. A slot opening through which currency, forms, records, and documents can be inserted.

d. A mechanical device that will close and lock the slot opening upon removal of the container from the gaming table.

12.5(2) Keys referred to in this rule shall be maintained and controlled by the security department in a secured area. The facility shall establish a sign-out procedure for all keys removed from the secured area.

491—12.6(99F) Accepting currency at gaming tables. Whenever currency is presented by a patron at a gaming table in exchange for gaming chips, the following procedures and requirements shall be observed:

12.6(1) The dealer or boxperson accepting the currency shall spread the currency on the top of the gaming table.

12.6(2) The dealer or boxperson shall verbalize the currency value in a tone of voice necessary to be heard by the patron and the casino supervisor assigned to the gaming table.

12.6(3) The dealer or boxperson shall take the currency from the top of the gaming table and place it into the container immediately after verbalizing the amount.

491—12.7(99F) Forms for the movement of gaming chips to and from gaming tables.

12.7(1) A request shall be prepared by a casino supervisor or a casino clerk to authorize the preparation of a slip for the movement of gaming chips. The request shall be a two-part form and access to the form shall, prior to use, be restricted to casino supervisors and casino clerks.

12.7(2) On the original and duplicate requests, the following information shall be recorded:

a. The date and time of preparation.

b. The total amount of each denomination.

c. The total amount of all denominations.

d. The game and table number.

e. The signature of the casino supervisor. Additionally, for credit requests, the signature of the dealer or boxperson assigned to the gaming table.

12.7(3) Slips shall be serially prenumbered forms; each series of slips shall be used in sequential order and the series numbers of all slips received by a casino shall be accounted for by employees who shall have segregation of incompatible functions. Whenever it becomes necessary to void a slip, the original and duplicate slips must clearly be marked "void" and shall require the signature of the preparer.

12.7(4) For facilities in which slips are manually prepared, the following procedures and requirements shall be observed:

a. Each series of slips shall be a three-part form and shall be inserted in a locked dispenser that will permit an individual slip in the series and its copies to be written upon simultaneously while still locked in the dispenser and will discharge the original and duplicate slips while the triplicate remains in a continuous unbroken form in the dispenser.

b. Access to the triplicates shall be maintained and controlled at all times by employees responsible for controlling and accounting for the unused supply of slips, placing slips in the dispensers, and removing from the dispensers, each gaming day, the triplicates remaining therein. The employees shall have segregation of incompatible functions.

12.7(5) For facilities in which slips are computer-prepared, each series of slips shall be a two-part form and shall be inserted in a printer that will simultaneously print an original and a duplicate and store, in machine-readable form, all information printed on the original and duplicate and discharge in the cashier's cage the original and duplicate. The stored data shall not be susceptible to change or removal by any personnel after preparation of a slip.

12.7(6) On original, duplicate, and triplicate slips or in stored data, the preparer shall record the following information:

a. The date and time of preparation.

b. The total amount of each denomination.

c. The total amount of all denominations.

d. The game and table number.

e. The signature of the preparer or, if computer-prepared, the identification code of the preparer.

12.7(7) The original and duplicate slips shall contain signatures of the following personnel at the following times attesting to the accuracy of the information contained on the slips:

a. The cashier upon preparation.

b. The security employee, or other employee authorized by the internal controls, upon receipt of the gaming chips to be transported to or from the cashier's cage.

c. The dealer or boxperson assigned to the gaming table upon receipt of the gaming chips at the table from a security employee, or other employee authorized by the internal controls.

d. The casino supervisor assigned to the gaming table upon receipt of the gaming chips at the table.

12.7(8) The original and duplicate void slips, void and error reports, requests, and the original slip, maintained and controlled in conformity with subrule 12.8(6) or 12.9(4), shall be forwarded using one of the following alternatives:

a. Forwarded to the count team for agreement with the duplicate slip and duplicate request, and the original and duplicate slip shall be forwarded to the accounting department for agreement, on a daily basis, with the triplicate or stored data.

b. Forwarded to the accounting department for agreement, on a daily basis, with the duplicate slip and duplicate request removed from the container and the triplicate or stored data.

491—12.8(99F) Distribution of gaming chips to gaming tables.

12.8(1) After preparation of a request, the original request shall be transported directly to the cashier's cage.

12.8(2) The dealer or boxperson shall place the duplicate request in public view on the gaming table to which the gaming chips are to be received. The duplicate request shall not be removed until the chips are received.

12.8(3) If slips are computer-prepared, and the input data required for preparation complies with subrule 12.7(2), subrules 12.8(1) and 12.8(2) shall not apply.

12.8(4) A slip shall be prepared by a cashier.

12.8(5) All gaming chips distributed to the gaming tables from the cashier's cage shall be transported to the gaming tables from the cashier's cage by a security employee, or other employee authorized by the internal controls, who shall compare the original request to the slip and sign the original request, maintained at the cashier's cage, before transporting the gaming chips and the original and duplicate slips.

12.8(6) Upon meeting the signature requirements as described in subrule 12.7(7), the employee that transported the gaming chips and the original and duplicate slips to the table shall observe the immediate placement by the dealer or boxperson of the original slip and the duplicate request in the container of the gaming table to which the gaming chips were transported and return or observe the return of the duplicate slip to the cashier's cage where the duplicate slip and original request shall be maintained together and controlled by a cashier.

491—12.9(99F) Removal of gaming chips from gaming tables.

12.9(1) Immediately upon preparation of a request and transfer of gaming chips to a security employee, or other employee authorized by the internal controls, a casino supervisor shall obtain on the duplicate request the signature of the employee to whom the gaming chips were transferred. The dealer or boxperson shall then place the duplicate request in public view on the gaming table from which the gaming chips were removed. The duplicate request shall not be removed until a slip is received from a cashier.

12.9(2) The security employee, or other employee authorized by the internal controls, shall transport the original request and the gaming chips removed from the gaming table directly to the cashier's cage.

12.9(3) Slips shall be prepared by a cashier or, if computer-prepared, by a cashier, casino supervisor, or casino clerk, whenever gaming chips are returned from the gaming tables to the cashier's cage.

12.9(4) Upon meeting the signature requirements as described in subrule 12.7(7), the security employee, or other employee authorized by the internal controls, shall transport the original and duplicate slips to the gaming table. The employee transporting the original and duplicate slips shall observe the immediate placement by the dealer or boxperson of the duplicate slip and duplicate request in the container attached to the gaming table from which the gaming chips were removed. The security employee or the casino clerk shall expeditiously return the original slip to the cashier's cage where the original slip and original request shall be maintained and controlled by employees independent of the casino department.

491—12.10(99F) Dropping or opening a gaming table.

12.10(1) The table inventory slips shall be two-part forms, the original marked "closer" and the duplicate marked "opener," containing the following:

a. The date and time of preparation.

b. The game and table number.

c. The total value of each denomination of gaming chips.

d. The total value of all denominations of gaming chips.

12.10(2) Whenever a gaming table is dropped or upon initial opening after a drop, the gaming chips at the gaming table shall be counted by the dealer or boxperson assigned to the gaming table while observed by a casino supervisor assigned to the gaming table.

12.10(3) Signatures attesting to the accuracy of the information recorded on the table inventory slips at the time of dropping or opening of the gaming tables shall be of the dealer or boxperson and the casino supervisor assigned to the gaming table who observed the dealer or boxperson count the contents of the table inventory.

12.10(4) Upon meeting the signature requirements described in subrule 12.10(3):

a. The closer, at dropping, shall be deposited in the container immediately prior to the closing of the table. The opener and the gaming chips remaining at the table shall be placed in a secured locked area on the table.

b. The opener, at opening, shall be immediately deposited in the container.

12.10(5) Upon opening a gaming table, if the totals on the gaming inventory form vary from the opening count, the casino supervisor shall fill out an error notification slip. The casino supervisor and dealer or boxperson shall sign the error notification slip and deposit the slip in the container.

491—12.11(99F) Slot machines—keys.

12.11(1) Each slot machine shall have a container(s) that is housed in a locked compartment(s) separate from any other compartment of the slot machine. Facilities shall ensure:

a. Keys to each compartment securing a container are maintained and controlled in a secured area by the security department. The facility shall establish a sign-out procedure for all keys removed from the secured area.

b. Each container is identified at time of removal by a number corresponding to the casino number of the slot machine from which the container is removed.

12.11(2) With the exception of the keys to the compartment housing the container, keys to each slot machine or any device connected thereto which may affect the operation of the slot machine shall be maintained in a secure place and controlled by the slot department.

491—12.12(99F) Forms for hopper fills and jackpot payout slips.

12.12(1) Slips shall be serially prenumbered forms. Each series of slips shall be used in sequential order, and the series numbers of all slips received by a casino shall be accounted for by employees independent of the cashier's cage and the slot department. Whenever it becomes necessary to void a slip, the original and duplicate slips must clearly be marked "void" and shall require the signature of the preparer. A serially prenumbered combined slip may be utilized as approved by a commission representative provided that the combined slip shall be used in a manner which otherwise complies with this chapter.

12.12(2) For facilities in which slips are manually prepared, the following procedures and requirements shall be observed:

a. Each series of slips shall be a three-part form and shall be inserted in a locked dispenser that will permit an individual slip in the series and its copies to be written upon simultaneously while still locked in the dispenser and will discharge the original and duplicate slips while the triplicate remains in a continuous unbroken form in the dispenser.

b. Access to the triplicates shall be maintained and controlled at all times by employees responsible for controlling and accounting for the unused supply of slips, placing slips in the dispensers, and removing from the dispensers, each gaming day, the triplicates remaining therein. The employees shall have segregation of incompatible functions.

12.12(3) For facilities in which slips are computer-prepared, each series of slips shall be a two-part form and shall be inserted in a printer that will simultaneously print an original and a duplicate and store, in a machine-readable form, all information printed on the original and duplicate and discharge the original and duplicate slips. The stored data shall not be susceptible to change or removal by any personnel after the preparation of a slip.

12.12(4) On original, duplicate, and triplicate slips or in stored data, the preparer shall record the following information:

a. The casino number of the slot machine.

b. The date and time of preparation.

c. For fills, the denomination and amount of coins to be distributed.

d. For jackpots, the amount to be paid and the slot booth or cage location from which the amount is to be paid. For jackpots, the winning combination of symbols and the amount to be paid.

e. The signature or, if computer-prepared, identification code of the preparer.

12.12(5) At the end of each gaming day, the original and duplicate slips shall be forwarded as follows:

a. The original slip shall be forwarded to the accounting department for agreement with the triplicate or stored data.

b. The duplicate slip shall be forwarded directly to the accounting department for recording on the slot win sheet for agreement with the meter readings recorded on the slot meter sheet and agreement with the triplicate or stored data.

491—12.13(99F) Hopper fills.

12.13(1) Whenever a slot machine hopper is empty and a fill is required, a slip shall be prepared.

12.13(2) Signatures attesting to the accuracy of the information contained on the slip shall be of the following personnel at the following times:

a. The original and duplicate slips:

(1) The cashier upon preparation of the slips.

(2) An employee authorized by the internal controls, upon receipt of the coins, who shall transport the coins and the duplicate slip to the slot machine.

b. The duplicate slip: By an employee authorized by the internal controls, other than the employees listed in 12.13(2)*"a,"* after observing the deposit of or depositing the coins in the slot machine and closing and locking the slot machine.

12.13(3) Upon meeting the signature requirements as described in paragraphs 12.13(2)*"a"* and *"b,"* the duplicate slip shall be deposited in a secured area controlled by the accounting department. The cashier shall maintain and control the original slip.

12.13(4) If an empty hopper is a result of machine malfunction, a slot technician will repair the machine before play of the machine is resumed.

12.13(5) If a facility requests the use of reserve fill compartments, an approved internal control fill procedure that complies with the intent of this rule may be substituted.

12.13(6) Fill bags received from a coin redemption employee shall be independently verified by a fill cashier prior to distribution to a slot machine.

491—12.14(99F) Jackpot, credit, and ticket payouts.

12.14(1) Whenever a patron wins a jackpot or has accumulated credits not totally and automatically paid directly from a slot machine, a cashier shall prepare a slip.

12.14(2) Signatures attesting to the accuracy of the information contained on the slip shall be of the following personnel at the following times:

a. The original and duplicate slips:

(1) The cashier upon preparation of the slips.

(2) An employee authorized by the internal controls, after observing the winning symbols or credit meter lock-up on the slot machine, who shall transport the jackpot payment and the duplicate slip directly to the patron.

b. The duplicate slip:

(1) An employee authorized by the internal controls, other than the employees listed in 12.14(2)*"a,"* after observing the payout.

(2) A supervisor after observing the symbols of the slot machine if the jackpot is in excess of $10,000.

12.14(3) Upon meeting the signature requirements as described in paragraphs 12.14(2)*"a"* and *"b,"* the duplicate slip shall be deposited in a secured area controlled by the accounting department. The cashier shall maintain and control the original slip.

12.14(4) For a slot machine jackpot in excess of $100,000, a facility shall notify a commission representative in accordance with the immediate notification process established by subrule 5.4(5).

12.14(5) If a facility proposes modifications to jackpot payment procedures, an approved internal control jackpot payout procedure that complies with the intent of this rule may be substituted.

12.14(6) Under this rule, unless otherwise subject to Iowa Code chapter 556, jackpots and accumulated credits paid by a slip that are unpaid or unclaimed at the close of a facility's fiscal year shall be disallowed as a deduction from gross receipts for the calculation of adjusted gross revenue for the wagering tax. A facility shall make this adjustment to revenue within 90 days of the close of the facility's fiscal year.

12.14(7) Payouts dispensed by a ticket issued directly from a slot machine must have a minimum redemption period of 90 days from the date of issue.

a. Notwithstanding 491—subrule 5.4(14), an issued ticket redeemed for cash or deposited in a slot machine for machine credits shall be retained for a minimum of 90 days from the redemption date. The ticket may be subsequently destroyed, if record of the transaction is retrievable by other means.

b. At the close of a facility's fiscal year, tickets issued in previous fiscal years and tickets with expired redemption periods that remain outstanding and unredeemed are subject to the requirements of subrule 12.14(6).

491—12.15(99F) Computer recording requirements and monitoring of slot machines.

12.15(1) A facility shall have a computer connected to each slot machine in the casino to record and monitor the slot machine's activities.

12.15(2) The computer shall be designed and operated to automatically perform the functions relating to slot machine meters in the casino as follows:

a. Record the number and total of moneys placed in the slot machine for the purpose of activating play.

b. Record the number and total of moneys in the container(s).

c. Record the number and total of moneys to be paid manually as the result of a jackpot.

d. Record the electronic meter information required by 491—subrule 11.10(4).

12.15(3) The computer shall monitor and detect machine exception codes and error messages as required by 491—subrule 11.10(5) and 491—11.11(99F).

12.15(4) The computer shall store in machine-readable form all information required by subrules 12.15(2) and 12.15(3) and the stored data shall not be susceptible to change or removal.

491—12.16(99F) Transportation of containers.

12.16(1) Each facility shall place on file with a commission representative a schedule setting forth the specific times at which the containers will be brought to or removed from the gaming tables or slot machines.

12.16(2) A security employee shall accompany and observe the drop team. For table games, all containers removed from the gaming tables shall be transported by a security employee and a table game supervisor.

12.16(3) All containers removed from slot machine cabinets shall:

a. Be removed by a drop team who shall wear outer garments as required by subrule 12.18(2).

b. Be replaced immediately with an empty container that shall be secured in the cabinet.

12.16(4) All containers removed shall be transported directly to, and secured in, the count room or in a secured area within the facility until the containers can be transferred to the count room.

12.16(5) Empty containers, not secured to the gaming tables or slot machine cabinets, shall be stored in the count room or an approved secured location.

491—12.17(99F) Count room—characteristics.

12.17(1) Each facility shall have a count room that shall:

a. Be designed and constructed to provide maximum security for materials housed within and the activities conducted therein.

b. Have an alarm device connected to the entrance of the room that causes a signaling to the monitors of the closed circuit television system and to the commission representative's office whenever the door to the room is opened.

c. Have, if currency is counted within, a count table constructed of clear glass or similar material for the emptying, counting, and recording of the contents of containers.

12.17(2) All room keys shall be maintained and controlled by the security department in a secured area. The facility shall establish a sign-out procedure for all keys removed from the secured area.

491—12.18(99F) Opening, counting, and recording contents of containers in the count room.

12.18(1) Each facility shall file with a commission representative the specific times and procedures for opening, counting, and recording the contents of containers.

12.18(2) All persons present in the count room during the counting process, unless expressly exempted by a commission representative, shall wear a full-length, one-piece, pocketless outer garment with openings only for the arms, feet, and neck that extends over any other garments and covers the tops of any footwear.

12.18(3) Persons shall not:

a. Carry a pocketbook or other container into the count room, unless it is transparent.

b. Remove their hands from or return them to a position on or above the count table unless the backs and palms of the hands are first held straight out and exposed to the view of other members of the count team and the closed circuit television camera.

12.18(4) Requirements for conducting the count.

a. Immediately prior to the commencement of the count, the count team shall notify the person assigned to the surveillance room that the count is about to begin, after which the surveillance department shall make a video recording with the time and date inserted thereon of the entire counting process.

b. Prior to counting the contents of the containers, the doors to the count room shall be locked and no person shall be permitted to enter or leave the count room, except during an emergency or on scheduled breaks, until the entire counting, recording, and verification process is completed. During this time, a commission representative shall have unrestricted access.

c. When a container is placed on a count table or coin scale, the count team shall ensure that the table or machine number associated with a container is identified to the surveillance department.

d. A machine may be used to automatically count the contents of a container.

e. The contents of each container shall be emptied on the count table or coin scale and either manually counted separately on the count table or counted in an approved currency counting machine located in a conspicuous location on, near, or adjacent to the count table or coin scale. These procedures shall at all times be conducted in full view of the closed circuit television cameras located in the count room.

f. Immediately after the contents of a container are emptied onto the count table or coin scale, the inside of the container shall be held up to the full view of a closed circuit television camera and shall be shown to at least one other count team member to ensure all contents of the container have been removed and, if applicable, the container shall then be locked. Empty containers shall be secured in an area separate from uncounted containers.

g. If the original count is being performed by a machine that automatically counts and records the amounts of the contents of each individual container, an aggregate count may be permitted in substitution of a second container count.

h. For manually counted containers:

(1) The count team members shall place the contents of each container into separate stacks on the count table by denomination of moneys and by type of form, record, or document, except that a machine may be used to automatically sort moneys by denomination.

(2) Each denomination of moneys shall be counted separately by one count team member who shall group moneys of the same denomination on the count table in full view of a closed circuit television camera. The moneys shall then be counted by a second count team member who is unaware of the result of the original count. The second count team member, after completing this count, shall confirm the accuracy of the total, either orally or in writing, with that reached by the first count team member.

12.18(5) Table games.

a. As the contents of each container from a table game are counted, one count team member shall record the following information by game, table number, date, and time on a master game report or supporting documents:

(1) The amount of each denomination of currency.
(2) The amount of all denominations of currency.
(3) The amount of coin.
(4) The total amounts of moneys.
(5) The amount of the opener.
(6) The amount of the closer.
(7) The serial number and amount of each fill.
(8) The amount of all fills.
(9) The serial number and amount of each credit.
(10) The amount of all credits.
(11) The win or loss.

b. After the contents of each container are counted and recorded, one member of the count team shall record by game on the master game report the total amounts of moneys, table inventory slips, fills, credits, and win or loss together with any other required information.

c. Notwithstanding the requirements of paragraphs 12.18(5)*"a"* and *"b,"* if the internal controls allow for the recording of fills, credits, and table inventory slips on the master game report or supporting documents prior to

commencement of the count, a count team member shall compare for agreement the totals of the amounts recorded thereon to the fills, credits, and table inventory slips removed from the containers.

d. After preparation of the master game report, each count team member shall sign the report attesting to the accuracy of the information contained thereon.

e. Moneys shall not be removed from the count room after commencement of the count until the moneys total has been verified and accepted by a cashier. At the conclusion of the count, all moneys removed from the containers shall be counted by a cashier in the presence of a count team member prior to having access to the information recorded on the master game report. The cashier shall attest to the accuracy of the amount of moneys received from the gaming tables by signature on the master game report, after which a count team member shall sign the master game report evidencing the fact that both the cashier and count team have agreed on the total amount of moneys counted. The verified funds shall then remain in the custody of the cashier.

f. After the master game report has been signed, the requests, slips, and table inventory slips removed from containers shall be attached. The report, with attachments, shall then be transported directly to the accounting department or shall be maintained in locked storage until the master game report can be delivered to the accounting department. Upon meeting the signature requirements described in paragraph 12.18(5)*"e,"* the report shall not be available to any cashier's cage personnel.

g. Unless the internal controls provide for the forwarding of the original requests and original slips from the cashier's cage directly to the accounting department, the original requests and original slips recorded or to be recorded on the master game report shall be transported from the count room directly to the accounting department.

h. The originals and copies of the master game report, requests, slips, table inventory slips, and the test receipts from the currency counting equipment shall, on a daily basis in the accounting department, be:

(1) Compared for agreement with each other on a test basis if the originals are received from the count room by persons with no recording responsibilities and, if applicable, to triplicates or stored data.

(2) Reviewed for the appropriate number and propriety of signatures on a test basis.

(3) Accounted for by series numbers, if applicable.

(4) Verified for proper calculation, summarization, and recording.

(5) Recorded.

(6) Maintained and controlled by the accounting department as a permanent accounting record.

12.18(6) Slot machines.

a. Moneys shall not be removed from the count room after commencement of the count until the moneys total has been verified and accepted by a cashier. At the conclusion of the count, all moneys removed from the containers shall be counted by a cashier in the presence of a count team member prior to the recording of information on the slot drop sheet. The cashier shall attest to the accuracy of the amount of moneys received from the slot machines by signature on the slot drop sheet, after which a count team member shall sign the slot drop sheet evidencing the fact that both the cashier and count team have agreed on the total amount of moneys counted. The verified funds shall remain in the custody of the cashier.

b. The slot drop sheet and supporting documents shall be transported directly to the accounting department and shall not be available, except for signing, to any cashier's cage or slot personnel or shall be maintained in locked storage until they can be delivered to the accounting department.

c. The preparation of the slot drop sheet shall be completed by accounting employees as follows:

(1) Compare the amount of moneys counted and the drop meter reading for agreement for each slot machine.

(2) Record the hopper fills for each slot machine.

(3) Record for each slot machine the payouts and compare for agreement the payouts to the manual jackpot meter reading recorded on the slot meter sheet.

(4) Calculate and record the win or loss for each slot machine.

(5) Explain and report for corrections of apparent meter malfunctions to the slot department all significant differences between meter readings and amounts recorded.

(6) Calculate statistics by slot machine.

d. The slot drop sheet, the slot meter sheet, payouts, and hopper fills shall be:

(1) Compared for agreement with each other and to triplicates or stored data on a test basis.

(2) Reviewed for the appropriate number and propriety of signatures on a test basis.

(3) Accounted for by series numbers, if applicable.

(4) Verified for proper calculation, summarization, and recording.

(5) Recorded.

(6) Maintained and controlled by accounting employees.

These rules are intended to implement Iowa Code chapter 99F.

[Filed 10/13/00, Notice 9/6/00—published 11/1/00, effective 12/6/00]
[Filed 4/24/01, Notice 2/7/01—published 5/16/01, effective 6/20/01]
[Filed 4/21/04, Notice 2/4/04—published 5/12/04, effective 6/16/04]
[Filed 4/21/06, Notice 2/15/06—published 5/10/06, effective 6/14/06]
[Filed 4/20/07, Notice 2/14/07—published 5/9/07, effective 6/13/07]
[Filed 6/6/08, Notice 3/26/08—published 7/2/08, effective 8/6/08]

CHAPTERS 13 to 26
Reserved

TITLE I
GENERAL
TITLE I
GENERAL

CHAPTER 1
OPERATION OF ENVIRONMENTAL PROTECTION COMMISSION

[Prior to 12/3/86, see Water, Air and Waste Management[900] Ch 2]

567—1.1(17A,455A) Scope. This chapter governs the conduct of business by the environmental protection commission. Rule-making proceedings held as part of commission meetings and contested case proceedings involving the commission are governed by other rules of the department.

567—1.2(17A,455A) Time of meetings. The commission meets at least quarterly, and usually meets monthly. The director, the chairperson, or a majority of the commission may establish meetings. Normally, the time of the next meeting will be determined in the current commission meeting.

567—1.3(17A,455A) Place of meetings. Meetings are generally held in the Henry A. Wallace Building, 900 East Grand Avenue, Des Moines, Iowa. The commission may meet at other locations from time to time; if so, the meeting place will be specified in the agenda.

567—1.4(17A,455A) Notification of meetings. The director of the department shall provide public notice of all meeting dates, locations, and tentative agenda.

1.4(1) *Form of notice.* Notice of meetings is given by posting the tentative agenda and by distribution upon request. The agenda lists the time, date, place, and topics to be discussed at the meeting. The agenda shall include a specific time for the public to address the commission on any issue related to the duties and responsibilities of the commission, except as otherwise provided in these rules.

1.4(2) *Posting of agenda.* The tentative agenda for each meeting will be posted at the department's offices on the fourth and fifth floors, Henry A. Wallace Building, normally at least seven days prior to the meeting. Agenda will be posted at least 24 hours prior to the meeting, unless for good cause such notice is impossible or impractical, in which case as much notice as is reasonably possible will be given.

1.4(3) *Distribution of agenda.* Agenda will be mailed to anyone who files a request with the director. The request should state whether the agenda for a particular meeting is desired, or whether the requester desires to be on the department's mailing list to receive the agenda for all meetings of the environmental protection commission.

1.4(4) *Amendment to agenda.* Any amendments to the agenda after posting and distribution under subrules 1.4(2) and 1.4(3) will be posted, but will not be mailed. The amended agenda will be posted at least 24 hours prior to the meeting, unless for good cause such notice is impossible or impractical, in which case as much notice as is reasonably possible will be given. The commission may adopt amendments to the agenda at the meeting only if good cause exists requiring expeditious discussion or action. The reasons and circumstances necessitating agenda amendments, or those given less than 24 hours' notice by posting, shall be stated in the minutes of the meeting.

1.4(5) *Supporting material.* Written materials provided to the commission with the agenda may be examined and copied as provided. Copies of the materials may be distributed at the discretion of the director to persons requesting the materials. The director may require a fee to cover the reasonable cost to the department to provide the copies, in accordance with rules of the department.

567—1.5(17A,455A) Attendance and participation by the public.

1.5(1) *Attendance.* All meetings are open to the public. The commission may exclude the public from portions of the meeting in accordance with Iowa Code section 21.5.

1.5(2) *Participation.*

a. Items on agenda. Presentations to the commission may be made at the discretion of the chairperson.

b. Items not on agenda. Because Iowa Code section 21.4 requires the commission to give notice of its agenda, the commission discourages persons from raising matters not on the agenda. Persons who wish to address the commission on a matter not on the agenda should file a request with the director to place that matter on the agenda of the subsequent meeting.

c. Meeting decorum. The chairperson may limit participation as necessary for the orderly conduct of agency business.

1.5(3) *Use of cameras and recording devices.* Cameras and recording devices may be used during meetings provided they do not interfere with the orderly conduct of the meeting. The chairperson may order the use of these devices discontinued if they cause interference, and may exclude those persons who fail to comply with that order.

567—1.6(17A,455A) Quorum and voting requirements.

1.6(1) *Quorum.* Five or more commissioners present at a meeting constitutes a quorum.

1.6(2) *Voting.*

a. Voting requirements if eight or nine commissioners are currently appointed. If eight or nine commissioners are currently appointed to the environmental protection commission by the governor, then the affirmative votes of five or more commissioners shall be required to act on any matter within the jurisdiction of the commission.

b. Voting requirements if seven or fewer commissioners are currently appointed. If seven or fewer commissioners are currently appointed to the environmental protection commission by the governor, then the affirmative votes of four or more commissioners shall be required to act on any matter within the jurisdiction of the commission.

c. Voting requirements to close a meeting. Notwithstanding paragraph 1.6(2)*"a"* or 1.6(2)*"b,"* a vote to close a meeting shall require the concurrence of six or more members of the commission, or the concurrence of all members present if less than six members are present.

567—1.7(17A,455A) Conduct of meeting.

1.7(1) *General.* Meetings will be conducted in accordance with Robert's Rules of Order unless otherwise provided in these rules. Voting shall be by voice or by roll call. Voting shall be by voice unless a voice vote is inconclusive, a member of the commission requests a roll call, or the vote is on a motion to close a portion of a meeting. The chairperson shall announce the result of the vote.

1.7(2) *Voice votes.* All commission members present should respond when a voice vote is taken. The response shall be aye, nay, or abstain.

a. All members present shall be recorded as voting aye on any motion when there are no nay votes or abstentions heard.

b. Any member who abstains shall state at the time of the vote the reason for abstaining. The abstention and the reason for it shall be recorded in the minutes.

1.7(3) *Provision of information.* The chairperson may recognize any agency staff member for the provision of information relative to an agenda item.

567—1.8(17A,455A) Minutes, transcripts, and recordings of meetings.

1.8(1) *Recordings.* The director shall record by mechanized means each meeting, and shall retain the recording for at least one year. Recordings of closed sessions shall be sealed and retained at least one year.

1.8(2) *Transcripts.* The department does not routinely prepare transcripts of meetings. The department will have transcripts of meetings, except for closed sessions, prepared upon receipt of a request for a transcript and payment of a fee to cover the cost to the department of preparing the transcript.

1.8(3) *Minutes.* The director shall keep minutes of each meeting. Minutes shall be reviewed and approved by the commission, and retained permanently by the director. The approved minutes shall be signed by the director and the chairperson and secretary of the commission.

567—1.9(17A,455A) Officers and duties.

1.9(1) *Officers.* The officers of the commission are the chairperson, the vice chairperson, and the secretary.

1.9(2) *Duties.* The chairperson shall preside at meetings, and shall exercise the powers conferred upon the chairperson. The vice chairperson shall perform the duties of the chairperson when the chairperson is absent or when directed by the chairperson. The secretary shall supervise the preparation of minutes, make recommendations to the commission on approval or revision of the minutes, and act as parliamentarian.

567—1.10(17A,455A) Election and succession of officers.

1.10(1) *Elections.* Officers shall be elected annually during May.

1.10(2) *Succession.*

a. If the chairperson does not serve out the elected term, the vice chairperson shall succeed the chairperson for the remainder of the term. A special election shall be held to elect a new vice chairperson to serve the remainder of the term.

b. If the vice chairperson does not serve out the elected term, a special election shall be held to elect a new vice chairperson to serve the remainder of the term.

c. If the secretary does not serve out the elected term, a special election shall be held to elect a new secretary to serve the remainder of the term.

567—1.11(68B) Sales of goods and services.

1.11(1) *Prohibition.* An official shall not sell, either directly or indirectly, any goods or services to individuals, associations, or corporations subject to the regulatory authority of the department unless the department consents as provided in this rule.

1.11(2) *Definitions.*

"Association" means any profit or nonprofit entity that is not a "corporation" or an "individual" as defined in this rule, but does not include any "unit of government" as defined in this rule.

"Commission" means the environmental protection commission.

"Corporation" means "corporation" and "foreign corporation" as defined in Iowa Code sections 490.140 and 504A.2, but does not include any "unit of government" as defined in this rule.

"Department" means the department of natural resources.

"Goods" means personal property, tangible and intangible.

"Individual" means a human being and includes any individual doing business as a sole proprietorship.

"Official" means a member of the environmental protection commission.

"Sale" or *"sell"* means the process in which goods or services are provided in exchange for money or other valuable consideration. The term does not include purchases of goods or services, nor outside employment activities that constitute an employer-employee relationship.

"Services" means action, conduct or performance which furthers some end or purpose or which assists or benefits someone or something.

"Unit of government" means "United States," "state" and "governmental subdivision" as defined in Iowa Code section 490.140.

1.11(3) *Application for consent.* An application for consent must be signed by the official requesting consent and submitted as specified in subrule 1.11(4). The application must provide a clear statement of all relevant facts concerning the sale, specify the amount of compensation and how compensation is to be determined, and indicate the time period or number of transactions for which consent is requested. The application must also explain why the sale would not create a conflict of interest or provide financial gain by virtue of the applicant's position within the department.

1.11(4) *Consent procedure.* Applications for consent must be submitted to the director who will schedule the matter as an informational item at a meeting of the commission. When the informational item is considered, the applicant may explain the application and entertain questions. The director shall schedule the matter to be decided at the second meeting following its consideration as an informational item, at which time the commission shall consider written comments which have been filed with the director and entertain any oral comments. The commission shall approve or deny the application by voting in the same manner as it determines other matters, except that the applicant shall not vote.

1.11(5) *General conditions of consent.* Consent shall not be given to an official unless all of the following conditions are met:

a. This condition is satisfied if either of the following paragraphs is met:

(1) The duties or functions performed by the official are not related to the regulatory authority of the department over the individual, association or corporation; or

(2) The duties or functions performed by the official are not affected by the selling of goods or services to the individual, association or corporation.

b. The selling of the goods or services by the official does not include acting as an advocate to the department on behalf of the individual, association or corporation receiving the goods or services.

c. The selling of goods or services does not result in the official selling a good or service to the department on behalf of the individual, association or corporation.

1.11(6) *Class prohibitions and consent.*

a. The commission concludes that the sales of goods and services described in this paragraph, as a class, constitute the sale of a good or service which affects an official's functions. The department will not consent to sales which fall within the following categories unless there are unique facts surrounding a particular sale which clearly satisfy the conditions listed in subrule 1.11(5).

Sales which are prohibited by rule:

(1) Sales of department information or the sale of services necessary to gather department information, including but not limited to solicitation lists.

(2) Services utilized in the preparation of applications, reports, or other documents which may be approved or reviewed by the commission.

b. The commission concludes that sales of goods or services described in this paragraph do not, as a class, constitute the sale of a good or service which affects an official's functions. Application and department approval are not required for these sales unless there are unique facts surrounding a particular sale which would cause that sale to affect the official's duties or functions, would give the buyer an advantage in its dealings with the department, or otherwise present a conflict of interest.

Sales for which consent is granted by rule:

(1) Nonrecurring sales of goods and services if the official is not engaged for profit in the business of selling those goods or services.

(2) Sale of farm products at market prices to a buyer ordinarily engaged in the business of purchasing farm products.

(3) Sales of goods to general public at an established retail or consignment shop.

(4) Sale of legal, mechanical, or other services at market or customary prices. However, if an official's client or customer has a matter for decision before the commission, the official shall not participate in the discussion and voting on that matter unless consent has been obtained pursuant to subrules 1.11(3) and 1.11(4).

(5) Sale of goods at wholesale prices to a buyer ordinarily engaged in the business of purchasing wholesale goods for retail sale.

(6) Sale of creative works of art, including but not limited to sculpture and literary products, at market, auction, or negotiated prices. However, if an official's customer has a matter for decision before the commission directly or indirectly involving that good, the official shall not participate in the discussion and voting on that matter unless consent has been obtained pursuant to subrules 1.11(3) and 1.11(4).

(7) Sale of goods to general public at market or franchiser-established prices. However, if an official's customer has a matter for decision before the commission, the official shall not participate in the discussion and voting on that matter unless consent has been obtained pursuant to subrules 1.11(3) and 1.11(4).

1.11(7) *Effect of consent.* The consent must be in writing. The consent is valid only for the activities and period described in it and only to the extent that material facts have been disclosed and the actual facts are consistent with those described in the application. Consent can be revoked at any time by written notice to the official.

1.11(8) *Public information.* The application and consent are public records, open for public examination, except to the extent that disclosure of details would constitute a clearly unwarranted invasion of personal privacy or trade secrets and the record is exempt from disclosure under Iowa law.

1.11(9) *Effect of other laws.* Neither this rule nor any consent provided under it constitutes consent for any activity which would constitute a conflict of interest at common law or which violates any applicable statute or rule. Despite department consent under these rules, a sale of goods or services to someone subject to the jurisdiction of the agency may violate the gift law, bribery and corruption laws. It is the responsibility of the official to ensure compliance with all applicable laws and to avoid both impropriety and the appearance of impropriety.

These rules are intended to implement Iowa Code sections 17A.3(1)*"a,"* 68B.4 and 455A.6.

[Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]
[Filed emergency 11/27/85—published 12/18/85, effective 11/27/85]
[Filed 11/14/86, Notice 10/8/86—published 12/3/86, effective 1/7/87]
[Filed 7/30/93, Notice 5/12/93—published 8/18/93, effective 9/22/93]
[Filed emergency 6/13/08—published 7/2/08, effective 6/13/08]

CHAPTER 64
WASTEWATER CONSTRUCTION AND OPERATION PERMITS

[Prior to 7/1/83, DEQ Ch 19]
[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—64.1(455B) Definitions. In addition to the definitions in Iowa Code sections 455B.101 and 455B.171, the following definitions shall apply to this chapter.

64.1(1) *"Application for construction permit"* means the engineering report, plans and specifications and other data deemed necessary by the department for the construction of a proposed wastewater disposal system or part thereof.

64.1(2) *"Construction permit"* means a written approval of the director to construct a wastewater disposal system or part thereof in accordance with the plans and specifications approved by the department.

64.1(3) *"Application for operation permit"* means an application for a written operation permit made on a form provided by the department.

64.1(4) *"Operation permit"* means a written permit by the director authorizing the operation of a wastewater disposal system or part thereof or discharge source, and, if applicable, the discharge of wastes from said disposal system or part thereof or discharge source to waters of the state. An operation permit will be issued as an NPDES permit if the regional administrator has approved the department's NPDES program and an NPDES permit is required for the disposal system.

64.1(5) *"Private sewage disposal system"* means a system which provides for the treatment or disposal of domestic sewage from four or fewer dwelling units or the equivalent of less than 16 individuals on a continuing basis.

64.1(6) *"Semipublic sewage disposal system"* means a system for the treatment or disposal of domestic sewage which is not a private sewage disposal system and which is not owned by a city, a sanitary sewer district, or a designated and approved management agency under Section 208 of the Act (33 U.S.C. 1288).

567—64.2(455B) Permit to construct.

64.2(1) No person shall construct, install or modify any wastewater disposal system or part thereof or extension or addition thereto without, or contrary to any condition of, a construction permit issued by the director or by a local public works department authorized to issue such permits under 567—Chapter 9, nor shall any connection to a sewer extension in violation of any special limitation specified in a construction permit pursuant to 64.2(10), paragraph *"a," "b,"* or *"f"* be allowed by any person subject to the conditions of the permit.

64.2(2) The site for each new wastewater treatment plant or expansion or upgrading of existing facilities must be inspected and approved by the department prior to submission of plans and specifications. Applications must be submitted in accordance with 567—60.4(455B).

64.2(3) Site approval under 64.2(2) shall be based on the criteria contained in the Ten States Standards, design manuals published by the department, applicable federal guidelines and standards, standard textbooks, current technical literature and applicable safety standards. To the extent that separation distances of this subrule conflict with the separation distances of 567—subrule 23.5(1) or 23.5(2), the greater distance shall prevail. The following separation distances from treatment or lagoon water surface shall apply:

a. 1000 feet from the nearest inhabitable residence, commercial building, or other inhabitable structure. If the inhabitable or commercial building is the property of the owner of the proposed treatment facility, or there is written agreement with the owner of the building, the separation criteria shall not apply. Any such written agreement shall be filed with the county recorder and recorded for abstract of title purposes, and a copy submitted to the department.

b. 1000 feet from public shallow wells.

c. 400 feet from public deep wells.

d. 400 feet from private wells.

e. 400 feet from lakes and public impoundments.

f. 25 feet from property lines and rights-of-way.

When the above separation distances cannot be maintained for the expansion, upgrading or replacement of existing facilities, the separation distances shall be maintained at no less than 90 percent of the existing separation distance on the site, providing no data is available indicating that a problem has existed or will be created.

64.2(4) Applications for a construction permit must be submitted to the director in accordance with 567—60.4(455B) at least 120 days in advance of the date of start of construction.

64.2(5) The director shall act upon the application within 60 days of receipt of a complete application by either issuing a construction permit or denying the construction permit in writing unless a longer review period is required and the applicant is so notified in writing. Notwithstanding the 120-day requirement in 64.2(4), construction of the approved system may commence immediately after the issuance of a construction permit.

64.2(6) The construction permit shall expire if construction thereunder is not commenced within one year of the date of issuance thereof. The director may grant an extension of time to commence construction if it is necessary or justified, upon showing of such necessity or justification to the director.

64.2(7) The director may modify or revoke a construction permit for cause which shall include but not be limited to the following:

a. Failure to construct said wastewater disposal system or part thereof in accordance with the approved plans and specifications.

b. Violation of any term or condition of the permit.

c. Obtaining a permit by misrepresentation of facts or failure to disclose fully all material facts.

d. Any change during construction that requires material changes in the approved plans and specifications.

64.2(8) A construction permit shall not be required for the following:

a. Storm sewers or storm water disposal systems that transport only storm water.

b. Any new disposal system or extension or addition to any existing disposal system that receives only domestic or sanitary sewage from a building, housing or occupied by 15 persons or less.

64.2(9) Review of applications.

a. Review of applications for construction permits shall be based on the criteria contained in the "Iowa Wastewater Facilities Design Standards," the Ten States Standards, applicable federal guidelines and standards, standard textbooks, current technical literature and applicable safety standards. To the extent of any conflict between the above criteria the "Iowa Wastewater Facilities Design Standards" standards shall prevail.

b. The chapters of the "Iowa Wastewater Facilities Design Standards"* that apply to wastewater facilities projects, and the date of adoption of those chapters are:

Chapter		Date of Adoption
11.	Project submittals	April 25, 1979
12.	Iowa Standards for Sewer Systems	September 6, 1978 (Amended March 28, 1979 and May 20, 1987)
13.	Wastewater pumping stations and force mains	March 19, 1985
14.	Wastewater treatment works	March 22, 1984 (Amended May 20, 1987)
15.	Screening and grit removal	February 18, 1986
16.	Settling	March 22, 1984 (Amended May 20, 1987)
17.	Sludge handling & disposal	March 26, 1980
18.	Biological treatment	
	A. Fixed film media treatment	October 21, 1985
	B. Activated sludge	March 22, 1984
	C. Wastewater treatment ponds (Lagoons)	April 25, 1979 (Amended May 20, 1986 and May 20, 1987)
19.	Supplemental treatment processes	November 13, 1986
20.	Disinfection	February 18, 1986
21.	Land application of wastewater	April 25, 1979

*The design manual as adopted and amended is available upon request to department, also filed with administrative rules coordinator.

c. Variances from the design standards and siting criteria which provide in the judgment of the department for substantially equivalent or improved effectiveness may be requested when there are unique circumstances not

found in most projects. The director may issue variances when circumstances are appropriate. The denial of a variance may be appealed to the commission.

d. When reviewing the variance request the director may consider the unique circumstances of the project, direct or indirect environmental impacts, the durability and reliability of the alternative, and the purpose and intent of the rule or standard in question.

e. Circumstances that would warrant consideration of a variance (which provides for substantially equivalent or improved effectiveness) may include the following:

(1) The utilization of new equipment or new process technology that is not explicitly covered by the current design standards.

(2) The application of established and acceptable technologies in an innovative manner not covered by current standards.

(3) It is reasonably clear that the conditions and circumstances which were considered in the adoption of the rule or standard are not applicable for the project in question and therefore the effective purpose of the rule will not be compromised if a variance is granted.

64.2(10) Applications for sanitary sewer extension construction permits shall conform to the Iowa Standards for Sewer Systems, and approval shall be subject to the following:

a. A sanitary sewer extension construction permit may be denied if, at the time of application, the treatment facility treating wastewater from the proposed sewer is not in substantial compliance with its operating permit or if the treatment facility receives wastes in volumes or quantities that exceed its design capacity and interfere with its operation or performance.

If the applicant is operating under a compliance schedule which is being adhered to that leads to resolution of the substantial compliance issues or if the applicant can demonstrate that the problem has been identified, the planning completed, and corrective measures initiated, then the construction permit may be granted.

b. A sanitary sewer extension construction permit may be denied if bypassing has occurred at the treatment facility, except when any of the following conditions are being met:

(1) The bypassing is due to a combined sewer system, and the facility is in compliance with a long-term CSO control plan approved by the department.

(2) The bypassing occurs as a result of a storm with an intensity or duration greater than that of a storm with a return period of five years. (See App. A[1])

(3) The department determines that timely actions are being taken to eliminate the bypassing.

c. A sanitary sewer extension construction permit may be denied if an existing downstream sewer is or will be overloaded or surcharged, resulting in bypassing, flooded basements, or overflowing manholes, unless:

(1) The bypassing or flooding is the result of a precipitation event with an intensity or duration greater than that of a storm with a return period of two years. (See App. A[1]); or

(2) The system is under full-scale facility planning (I/I and SSES) and the applicant provides a schedule that is approved by the department for rehabilitating the system to the extent necessary to handle the additional loadings.

d. Potential loads. Construction permits may be granted for sanitary sewer extensions that are sized to serve future loads that would exceed the capacity of the existing treatment works. However, initial connections shall be limited to the load that can be handled by the existing treatment works. The department will determine this load and advise the applicant of the limit. This limitation will be in effect until additional treatment capacity has been constructed.

64.2(11) Certification of completion. Within 30 days after completion of construction, installation or modification of any wastewater disposal system or part thereof or extension or addition thereto, the permit holder shall submit a certification by a registered professional engineer that the project was completed in accordance with the approved plans and specifications.

[1] See end of chapter for Appendix A.

567—64.3(455B) Permit to operate.

64.3(1) Except as provided otherwise in this subrule and in 567—Chapter 65, no person shall operate any wastewater disposal system or part thereof without, or contrary to any condition of, an operation permit issued by the director; nor shall the permittee of a system to which a sewer extension has been made under a construction

permit limited pursuant to 64.2(10), paragraph *"a," "b"* or *"f,"* allows a connection to such sewer extension in violation of any special limitation in such construction permit. An operation permit is not required for the following:

a. Private sewage disposal system which does not discharge into a water of the state.

b. A semipublic sewage disposal system, the construction of which has been approved by the department and which does not discharge into a water of the state.

c. Any discharge of sewage from vessels, effluent from properly functioning marine engines, laundry, shower, and galley sink wastes, or any other discharge incidental to the normal operation of a vessel: Provided, that this exclusion shall not be construed to apply to rubbish, trash, garbage, or other such materials discharged overboard; nor to discharges when the vessel is being used in a capacity other than as a means of transportation.

d. Discharges to aquaculture projects as defined in 40 CFR §122.25 (eff. 12-18-84).

e. Discharges of dredged or fill material into navigable waters which are regulated under Section 404 of the Act.

f. Any discharge of pollutants directly to another waste disposal system for final treatment and disposal, with the exception of storm water point sources. (This exclusion from requiring an operation permit applies only to the actual addition of materials into the subsequent treatment works. Plans or agreements to make such additions in the future do not relieve dischargers of the obligation to apply for and receive permits until the discharges of pollutants to navigable waters are actually eliminated. It also should be noted that, in all appropriate cases, pretreatment standards promulgated by the administrator pursuant to Section 307(b) of the Act and adopted by reference by the commission and other pretreatment standards and requirements must be complied with.)

g. Any discharge in compliance with the instruction of an On-Scene Coordinator pursuant to 40 CFR Part 300 [The National Oil and Hazardous Substances Pollution Plan] or 33 CFR §153.10(e) [Pollution by Oil and Hazardous Substances].

h. Water pollution from agricultural and silvicultural activities, runoff from orchards, cultivated crops, pastures, rangelands, and forestlands, except that this exclusion shall not apply to the following:

(1) Discharges from concentrated aquatic animal production facilities as defined in 40 CFR §122.24 (eff. 12-18-84);

(2) Discharges from concentrated animal feeding operations as defined in 40 CFR §122.23 (eff. 12-18-84);

(3) Discharges from silvicultural point sources as defined in 40 CFR §122.27 (eff. 12-18-84);

(4) Storm water discharge associated with industrial activity as defined in 567—Chapter 60.

i. Return flows from irrigated agriculture.

64.3(2) Rescinded, effective 2/20/85.

64.3(3) The owner of any disposal system or part thereof in existence before August 21, 1973, for which a permit has been previously granted by the Iowa department of health or the Iowa department of environmental quality shall submit such information as the director may require to determine the conformity of such system and its operation with the rules of the department by no later than 60 days after the receipt of a request for such information from the director.

64.3(4) Applications.

a. Individual permit. Except as provided in 64.3(4)*"b"* or 64.3(4)*"c,"* applications for operation permits required under 64.3(1) shall be made on forms provided by the department. The application for an operation permit under 64.3(1) shall be filed at least 180 days prior to the date operation is scheduled to begin unless a shorter period of time is approved by the director. Permit applications for a new discharge of storm water associated with construction activity as defined in 567—Chapter 60 under "storm water discharge associated with industrial activity" must be submitted at least 60 days before the date on which construction is to commence. Applications submitted to the department must be accompanied by the appropriate permit fee as specified in rule 64.16(455B). The director shall issue operation permits for applications filed pursuant to 64.3(1) within 90 days of the receipt of a complete application unless the application is for an NPDES permit or unless a longer period of time is required and the applicant is so notified. The director may require the submission of additional information deemed necessary to evaluate the application. If the application is incomplete or otherwise deficient, processing of the application shall not be completed until such time as the applicant has supplied the missing information or otherwise corrected the deficiency.

b. General permit. A Notice of Intent for coverage under a general permit must be made on the appropriate form provided by the department listed in 567—subrule 60.3(2) and in accordance with 567—64.6(455B). A Notice of Intent must be submitted to the department according to the following:

(1) For existing storm water discharge associated with industrial activity, with the exception of discharges identified in subparagraphs (2) and (3) of this paragraph, on or before October 1, 1992.

(2) For any existing storm water discharge associated with industrial activity from a facility or construction site that is owned or operated by a municipality with a population of less than 100,000 other than an airport, power plant or uncontrolled sanitary landfill, on or before March 10, 2003.

For purposes of this subparagraph, municipality means city, town, borough, county, parish, district, association, or other public body created by or under state law. The entire population served by the public body shall be used in the determination of the population.

(3) For any existing storm water discharge associated with small construction activity on or before March 10, 2003.

(4) For storm water discharge associated with industrial activity which initiates operation after October 1, 1992, with the exception of discharges identified in subparagraphs (2) and (3) of this paragraph, where storm water discharge associated with industrial activity could occur as defined in rule 567—60.2(455B).

(5) For any private sewage disposal system installed after July 1, 1998, where subsoil discharge is not possible.

(6) For any discharge, except a storm water only discharge, from a mining or processing facility after July 18, 2001.

c. Group applications. Group applications identified in 40 CFR Part 122.26(c)(2) as amended through June 15, 1992, that were submitted and approved by the U.S. Environmental Protection Agency will be accepted by the department as an application for an NPDES permit for a storm water discharge associated with industrial activity. A copy of the group application does not need to be submitted to the department. The department will notify a participant in a group application of the required application and individual permit fees as specified in 64.16(3)*"b"* if an industry specific general permit is not available for the participants in the group.

64.3(5) Requirements for industries that discharge to another disposal system except storm water point sources.

a. The director may require any person discharging wastes to a publicly or privately owned disposal system to submit information similar to that required in an application for an operation permit, but no operation permit is required for such discharge.

Major contributing industries must submit a treatment agreement which meets the following criteria:

(1) The agreement must be on a form provided by the department; and

(2) Must identify and limit the monthly average and the daily maximum quantity of compatible and incompatible pollutants discharged to the disposal system and the variations in daily flow; and

(3) Be signed by the industrial contributor and the owner of the disposal system accepting the wastewater; and

(4) Provide that the quantities to be discharged to the disposal system must be in accordance with the applicable standards and requirements in 567—Chapter 62.

b. A major contributing industry should submit a new treatment agreement form 60 days in advance of a proposed expansion, production increase or process modification that may result in discharges of sewage, industrial waste, or other waste in excess of the discharge stated in the existing treatment agreement. An industry that would become a major contributing industry as a result of a proposed expansion, production increase or process modification should submit a treatment agreement form 60 days in advance of the proposed expansion, production increase or process modification.

c. A treatment agreement form must be submitted at least 180 days before a new major contributing industry proposes to discharge into a wastewater disposal system. The owner of a wastewater disposal system shall notify the director by submitting a complete treatment agreement to be received at least ten days prior to making any commitment to accept waste from a proposed new major contributing industry. However, the department may notify the owner that verification of the data in the treatment agreement may take longer than ten days and advise that the owner should not enter a commitment until the data is verified.

d. A treatment agreement form for each major contributing industry must be submitted with the facility plan or preliminary engineering report for the construction or modification of a wastewater disposal system. These agreements will be used in determining the design basis of the new or upgraded system.

e. Treatment agreement forms from major contributing industries shall be required as a part of the application for a permit to operate the wastewater disposal system receiving the wastes from the major contributing industry.

64.3(6) Rescinded, effective 7/23/86.

64.3(7) Operation permits may be granted for any period of time not to exceed five years. Applications for renewal of an operation permit must be submitted to the department 180 days in advance of the date the permit expires. General permits will be issued for a period not to exceed five years. Each permit to be renewed shall be subject to the provisions of all rules of the department in effect at the time of the renewal.

64.3(8) Identity of signatories of operation permit applications. The person who signs the application for an operation permit shall be:

a. Corporations. In the case of corporations, a principal executive officer of at least the level of vice president.

b. Partnerships. In the case of a partnership, a general partner.

c. Sole proprietorships. In the case of a sole proprietorship, the proprietor.

d. Public facilities. In the case of a municipal, state, or other public facility, by either the principal executive officer, or the ranking elected official.

e. Storm water discharge associated with industrial activity from construction activities. In the case of a storm water discharge associated with construction activity, either the owner of the site or the general contractor.

The person who signs NPDES reports shall be the same, except that in the case of a corporation or a public body, monitoring reports required under the terms of the permit may be submitted by the person who is responsible for the overall operation of the facility from which the discharge originates.

64.3(9) When necessary to comply with present standards which must be met at a future date, an operation permit shall include a schedule for the alteration of the permitted facility to meet said standards. Such schedules shall not relieve the permittee of the duty to obtain a construction permit pursuant to 64.2(455B). When necessary to comply with a pretreatment standard or requirement which must be met at a future date, a major contributing industry will be given a compliance schedule for meeting those requirements.

64.3(10) Operation permits shall contain such conditions as are deemed necessary by the director to ensure compliance with all applicable rules of the department, including monitoring and reporting conditions, to protect the public health and beneficial uses of state waters, and to prevent water pollution from waste storage or disposal operations.

64.3(11) The director may suspend or revoke in whole or in part any individual operation permit or coverage under a general permit for cause. Except for general permits, the director may modify in whole or in part any individual operation permit for cause. A variance or modification to the terms and conditions of a general permit shall not be granted. If a variance or modification to a general permit is desired, the applicant must apply for an individual permit following the procedures in 64.3(4)*"a."*

Cause for modification, suspension or revocation of a permit includes the following:

a. Violation of any term or condition of the permit.

b. Obtaining a permit by misrepresentation of fact or failure to disclose fully all material facts.

c. A change in any condition that requires either a temporary or permanent reduction or elimination of the permitted discharge.

d. Failure to submit such records and information as the director shall require both generally and as a condition of the operation permit in order to ensure compliance with the discharge conditions specified in the permit.

e. Failure or refusal of an NPDES permittee to carry out the requirements of 64.7(5)*"c."*

f. Failure to provide all the required application materials or appropriate fees.

567—64.4(455B) Issuance of NPDES permits.

64.4(1) *Individual permit.* The director shall, when an operation permit expires and an NPDES permit is required for the discharge, and, upon proper application, issue an individual NPDES permit in accordance with 64.5(455B), 64.7(455B), 64.8(1) and 64.9(455B).

64.4(2) *General permit.*

a. The director may issue general permits which are consistent with 64.4(2)*"b"* and the requirements specified in 64.6(455B), 64.7(455B), 64.8(2), and 64.9(455B) for the following activities:

(1) Storm water point sources requiring an NPDES permit pursuant to Section 402(p) of the federal Clean Water Act and 40 CFR 122.26 (as amended through June 15, 1992).

(2) Private sewage disposal system discharges permitted under IAC 567—Chapter 69 where subsoil discharge is not possible as determined by the administrative authority.

(3) For any discharge, except a storm water only discharge, from a mining or processing facility.

b. Each general permit issued by the department must:

(1) Be adopted as an administrative rule in accordance with Iowa Code chapter 17A, the Administrative Procedure Act. Each proposed permit will be accompanied by a fact sheet setting forth the principal facts and methodologies considered during permit development,

(2) Correspond to existing geographic or political boundaries, and

(3) Be identified in 567—64.15(455B).

c. If an NPDES permit is required for an activity covered by a general permit, the applicant may seek either general permit coverage or an individual permit. Procedures and requirements for obtaining an individual NPDES permit are detailed in 64.3(4)*"a."* Procedures for filing a Notice of Intent for coverage under a general permit are described in 567—64.6(455B) "Completing a Notice of Intent for Coverage Under a General Permit."

567—64.5(455B) Notice and public participation in the individual NPDES permit process.

64.5(1) *Formulation of tentative determination and draft NPDES permit.* The department shall make a tentative determination to issue or deny an NPDES permit for the discharge described in a Ref-~~~use Act or NPDES application in advance of the public notice of 64.5(2). If the tentative determination is to issue the NPDES permit, the department shall prepare a draft NPDES permit. The draft permit shall include the following:

a. Effluent limitations identified pursuant to 64.6(2) and 64.6(3), for those pollutants proposed to be limited.

b. If necessary, a proposed schedule of compliance, including interim dates and requirements, identified pursuant to 64.6(4), for meeting the effluent limitations and other permit requirements.

c. Any other special conditions (other than those required in 64.6(5)) which will have a significant impact upon the discharge described in the NPDES application.

64.5(2) *Public notice.*

a. Prior to the issuance of an NPDES permit, public notice shall be circulated in a manner designed to inform interested and potentially interested persons of the proposed discharge and of the tentative determination to issue or deny an NPDES permit for the proposed discharge. Procedures for the circulation of public notice shall include at least the procedures of subparagraphs (1) to (3).

(1) The public notice shall be circulated by the applicant within the geographical areas of the proposed discharge by posting the public notice in the post office and public places of the city nearest the premises of the applicant in which the effluent source is located; by posting the public notice near the entrance to the applicant's premises and in nearby places; and by publishing the public notice in local newspapers and periodicals, or, if appropriate, in a newspaper of general circulation.

(2) The public notice shall be mailed by the department to any person upon request.

(3) Upon request the department shall add the name of any person or group to the mailing list, described in 567—4.2(455B), to receive copies of all public notices concerning proposed NPDES permits within the state or within a certain geographical area and shall mail a copy of all public notices to such persons.

b. The department shall provide a period of not less than 30 days following the date of the public notice during which time interested persons may submit their written views on the tentative determinations with respect to the NPDES application. All written comments submitted during the 30-day comment period shall be retained by the department and considered by the director in the formulation of the director's final determinations with respect to the NPDES application. The period for comment may be extended at the discretion of the department.

c. The contents of the public notice of a proposed NPDES permit shall include at least the following:

(1) The name, address, and telephone number of the department.

(2) The name and address of each applicant.

(3) A brief description of each applicant's activities or operations which result in the discharge described in the NPDES application (e.g., municipal waste treatment plant, corn wet milling plant, or meat packing plant).

(4) The name of the waterway to which each discharge of the applicant is made and a short description of the location of each discharge of the applicant on the waterway indicating whether such discharge is a new or an existing discharge.

(5) A statement of the department's tentative determination to issue or deny an NPDES permit for the discharge or discharges described in the NPDES application.

(6) A brief description of the procedures for the formulation of final determinations, including the 30-day comment period required by paragraph *"b"* of this subrule and any other means by which interested persons may influence or comment upon those determinations.

(7) The address and telephone number of places at which interested persons may obtain further information, request a copy of the draft permit prepared pursuant to 64.5(1), request a copy of the fact sheet, if any, described in 64.5(3) and inspect and copy NPDES forms and related documents.

64.5(3) *Fact sheets.*

a. For every discharge which has a total volume of more than 500,000 gallons on any day of the year, the department shall prepare and, upon request, shall send to any person a fact sheet with respect to the application described in the public notice. The contents of such fact sheets shall include at least the following information:

(1) A sketch or detailed description of the location of the discharge described in the NPDES application.

(2) A quantitative description of the discharge described in the NPDES application which includes at least the following: the rate or frequency of the proposed discharge (if the discharge is continuous, the average daily flow in gallons per day or million gallons per day); for thermal discharges subject to limitation under the Act, the average summer and winter discharge temperatures in degrees Fahrenheit; and the average daily discharge in pounds per day of any pollutants which are present in significant quantities or which are subject to limitations or prohibition under Section 301, 302, 306 or 307 of the Act and regulations published thereunder.

(3) The tentative determinations required under 64.5(1).

(4) A brief citation, including a brief identification of the uses for which the receiving waters have been classified, of the water quality standards applicable to the receiving waters and effluent standards and limitations applicable to the proposed discharge.

(5) A fuller description of the procedures for the formulation of final determinations than that given in the public notice including: the 30-day comment period required by 64.5(2); procedures for requesting a public hearing and the nature thereof; and any other procedures by which the public may participate in the formulation of the final determinations.

b. Upon request the department shall add the name of any person or group to a mailing list, described in 4.2(455B), to receive copies of fact sheets and shall mail a copy of all fact sheets to such person.

64.5(4) *Notice to other government agencies.* Prior to the issuance of an NPDES permit, the department shall notify other appropriate government agencies of each complete application for an NPDES permit and shall provide such agencies an opportunity to submit their written views and recommendations. Procedures for such notification shall include the procedures of paragraphs *"a"* to *"d."*

a. At the time of issuance of public notice pursuant to 64.5(2), the department shall transmit the fact sheet, if any, to any other state whose waters may be affected by the issuance of the NPDES permit and, upon request, the department shall provide such state with a copy of the NPDES application and a copy of the proposed permit prepared pursuant to 64.5(1). Each affected state shall be afforded an opportunity to submit written recommendations to the department and to the regional administrator which the director may incorporate into the permit if issued. Should the director fail to incorporate any written recommendation thus received, the director shall provide to the affected state or states and to the regional administrator a written explanation of the reasons for failing to accept any written recommendation.

b. At the time of issuance of public notice pursuant to 64.5(2), the department shall mail the public notice for proposed discharges (other than minor discharges) into navigable waters and the fact sheet, if any, to the appropriate district engineer of the army corps of engineers.

(1) The department and the district engineer for each corps of engineers district within the state may arrange for: notice to the district engineer of minor discharges; waiver by the district engineer of the right to receive fact sheets with respect to classes, types, and sizes within any category of point sources and with respect to discharges to particular navigable waters or parts thereof; and any procedures for the transmission of forms, period of comment by the district engineer (e.g., 30 days), and for objections of the district engineer.

(2) A copy of any written agreement between the department and a district engineer shall be forwarded to the regional administrator and shall be available to the public for inspection and copying in accordance with 567—Chapter 4.

c. Upon request the department shall mail the public notice and fact sheet, if any, to any other federal, state, or local agency, or any affected country, and provide such agencies an opportunity to respond, comment, or request a public hearing pursuant to 64.5(6).

d. The department shall mail the public notice and fact sheet, if any, for any proposed NPDES permit within the geographical area of a designated and approved management agency under Section 208 of the Act (33 U.S.C. 1288).

e. The department shall mail the public notice and fact sheet, if any, to the local board of health for the purpose of assisting the applicant in coordinating the applicable requirements of the Act and Iowa Code chapter 455B with any applicable requirements of the local board of health.

64.5(5) *Public access to NPDES information.* The records of the department connected with NPDES permits are available for public inspection and copying to the extent provided in 567—Chapter 4.

64.5(6) *Public hearings on proposed NPDES permits.* The applicant, any affected state, the regional administrator, or any interested agency, person or group of persons may request or petition for a public hearing with respect to an NPDES application. Any such request shall clearly state issues and topics to be addressed at the hearing. Any such request or petition for public hearing must be filed with the director within the 30-day period prescribed in 64.5(2)*"b"* and shall indicate the interest of the party filing such request and the reasons why a hearing is warranted. The director shall hold an informal and noncontested case hearing if there is a significant public interest (including the filing of requests or petitions for such hearing) in holding such a hearing. Frivolous or insubstantial requests for hearing may be denied by the director. Instances of doubt should be resolved in favor of holding the hearing. Any hearing held pursuant to this subrule shall be held in the geographical area of the proposed discharge, or other appropriate area in the discretion of the director, and may, as appropriate, consider related groups of permit applications.

64.5(7) *Public notice of public hearings.*

a. Public notice of any hearing held pursuant to 64.5(6) shall be circulated at least as widely as was the notice of the NPDES application.

(1) Notice shall be published in at least one newspaper of general circulation within the geographical area of the discharge;

(2) Notice shall be sent to all persons and government agencies which received a copy of the notice or the fact sheet for the NPDES application;

(3) Notice shall be mailed to any person or group upon request; and

(4) Notice pursuant to subparagraphs (1) and (2) of this paragraph shall be made at least 30 days in advance of the hearing.

b. The contents of public notice of any hearing held pursuant to 64.5(6) shall include at least the following:

(1) The name, address, and telephone number of the department;

(2) The name and address of each applicant whose application will be considered at the hearing;

(3) The name of the waterway to which each discharge is made and a short description of the location of each discharge on the waterway;

(4) A brief reference to the public notice issued for each NPDES application, including identification number and date of issuance;

(5) Information regarding the time and location for the hearing;

(6) The purpose of the hearing;

(7) A concise statement of the issues raised by the person requesting the hearing;

(8) The address and telephone number of the premises where interested persons may obtain further information, request a copy of the draft NPDES permit prepared pursuant to 64.5(1), request a copy of the fact sheet, if any, prepared pursuant to 64.5(3), and inspect and copy NPDES forms and related documents; and

(9) A brief description of the nature of the hearing, including the rules and procedures to be followed.

567—64.6(455B) Completing a Notice of Intent for coverage under a general permit.

64.6(1) *Contents of a complete Notice of Intent.* An applicant proposing to conduct activities covered by a general permit shall file a complete Notice of Intent by submitting to the department materials required in paragraphs *"a"* to *"c"* of this subrule.

a. Notice of Intent Application Form. The following Notice of Intent forms must be completed in full.

(1) General Permit No. 1 "Storm Water Discharge Associated with Industrial Activity," Form 542-1415.

(2) General Permit No. 2 "Storm Water Discharge Associated with Industrial Activity for Construction Activities," Form 542-1415.

(3) General Permit No. 3 "Storm Water Discharge Associated with Industrial Activity from Asphalt Plants, Concrete Batch Plants, Rock Crushing Plants and Construction Sand and Gravel Facilities," Form 542-1415.

(4) General Permit No. 4 "Discharge from On-Site Wastewater Treatment and Disposal Systems," Form 542-1541.

(5) General Permit No. 5 "Discharge from Mining and Processing Facilities," Form 542-4006.

b. General permit fee. The general permit fee according to the schedule in 64.16(455B) payable to the Department of Natural Resources.

c. Public notification. The following public notification requirements must be completed for the corresponding general permit.

(1) General Permits No. 1, No. 2 and No. 3. A demonstration that a public notice was published in at least two newspapers with the largest circulation in the area in which the facility is located or the activity will occur. If a facility or activity authorized by General Permit No. 3 is to be relocated to a site not included in the original notice, a public notice need be published in only one newspaper. The newspaper notices shall, at the minimum, contain the following information:

PUBLIC NOTICE OF STORM WATER DISCHARGE

The (applicant name) plans to submit a Notice of Intent to the Iowa Department of Natural Resources to be covered under NPDES General Permit (select the appropriate general permit—No. 1 "Storm Water Discharge Associated with Industrial Activity" or General Permit No. 2 "Storm Water Discharge Associated with Industrial Activity for Construction Activities"). The storm water discharge will be from (description of industrial activity) located in (¼ section, township, range, county). Storm water will be discharged from (number) point source(s) and will be discharged to the following streams: (stream name(s)).

Comments may be submitted to the Storm Water Discharge Coordinator, IOWA DEPARTMENT OF NATURAL RESOURCES, Environmental Protection Division, 900 E. Grand Avenue, Des Moines, IA 50319-0034. The public may review the Notice of Intent from 8 a.m. to 4:30 p.m., Monday through Friday, at the above address after it has been received by the department.

(2) General Permit No. 4. There are no public notification requirements for this permit.

(3) General Permit No. 5. There are no public notification requirements for this permit.

64.6(2) *Authorization to discharge under a general permit.* Upon the submittal of a complete Notice of Intent in accordance with 64.6(1) and 64.3(4)*"b,"* the applicant is authorized to discharge after evaluation of the Notice of Intent by the department is complete and the determination has been made that the contents of the Notice of Intent satisfy the requirements of 567—Chapter 64. The discharge authorization date for all storm water discharges associated with industrial activity that are in existence on or before October 1, 1992, shall be October 1, 1992. The applicant will receive notification by the department of coverage under the general permit. If any of the items required for filing a Notice of Intent specified in 64.6(1) are missing, the department will consider the application incomplete and will notify the applicant of the incomplete items.

64.6(3) *General permit suspension or revocation.* In addition to the causes for suspension or revocation which are listed in 64.3(11), the director may suspend or revoke coverage under a general permit issued to a facility or a class of facilities for the following reasons and require the applicant to apply for an individual NPDES permit in accordance with 64.3(4)*"a"*:

a. The discharge would not comply with Iowa's water quality standards pursuant to 567—Chapter 61, or

b. The department finds that the activities associated with a Notice of Intent filed with the department do not meet the conditions of the general permit. The department will notify the affected discharger and establish a deadline, not longer than one year, for submitting an individual permit application.

64.6(4) *Eligibility for individual permit holders.* A person holding an individual NPDES permit for an activity covered by a general permit may apply for coverage under a general permit upon expiration of the individual permit and by filing a Notice of Intent according to procedures described in 64.3(4)*"b."*

64.6(5) *Filing a Notice of Discontinuation.* A notice to discontinue the activity covered by the NPDES general permit shall be made in writing to the department 30 days prior to or after discontinuance of the discharge. For storm water discharge associated with industrial activity for construction activities, the discharge will be considered as discontinued when "final stabilization" has been reached. Final stabilization means that all soil-disturbing activities at the site have been completed and that a uniform perennial vegetative cover with a density of 70 percent for the area has been established or equivalent stabilization measures have been employed.

The notice of discontinuation shall contain the following:

a. The name of the facility to which the permit was issued,

b. The general permit number and permit authorization number,

c. The date the permitted activity was, or will be, discontinued, and

d. A signed certification in accordance with the requirements in the general permit.

64.6(6) *Transfer of ownership—construction activity part of a larger common plan of development.* For construction activity which is part of a larger common plan of development, such as a housing or commercial development project, in the event a permittee transfers ownership of all or any part of property subject to NPDES General Permit No. 2, both the permittee and transferee shall be responsible for compliance with the provisions of the general permit for that portion of the project which has been transferred, including when the transferred property is less than one acre in area, from and after the date the department receives written notice of the transfer, provided that:

a. The transferee is notified in writing of the existence and location of the general permit and pollution prevention plan, and of the transferee's duty to comply, and proof of such notice is included with the notice to the department of the transfer.

b. If the transferee agrees, in writing, to become the sole responsible permittee for the property which has been transferred, then the transferee shall be solely responsible for compliance with the provisions of the general permit for the transferred property from and after the date the department receives written notice of the transferee's assumption of responsibility.

c. If the transferee agrees, in writing, to obtain coverage under NPDES General Permit No. 2 for the property which has been transferred, then the transferee is required to obtain coverage under NPDES General Permit No. 2 for the transferred property from and after the date the department receives written notice of the transferee's assumption of responsibility for permit coverage. After the transferee has agreed, in writing, to obtain coverage under NPDES General Permit No. 2 for the transferred property and the department has received written notice of the transferee's assumption of responsibility for permit coverage for the transferred property, the authorization issued under NPDES General Permit No. 2 to the transferor for the transferred property shall be considered by the department as not providing NPDES permit coverage for the transferred property and the transferor's authorization issued under NPDES General Permit No. 2 for, and only for, the transferred property, shall be deemed by the department as being discontinued without further action of the transferor.

d. All notices sent to the department as described in this subrule shall contain the name of the development as submitted to the department in the original Notice of Intent and as modified by any subsequent written notices of name changes submitted to the department, the authorization number assigned to the authorization by the department, the legal description of the transferred property including lot number, if any, and any other information necessary to precisely locate the transferred property and to establish the legality of the document.

567—64.7(455B) Terms and conditions of NPDES permits.

64.7(1) *Prohibited discharges.* No NPDES permit may authorize any of the discharges prohibited by 567—62.1(455B).

64.7(2) *Application of effluent, pretreatment and water quality standards and other requirements.* Each NPDES permit shall include any of the following that is applicable:

a. An effluent limitation guideline promulgated by the administrator under Sections 301 and 304 of the Act and adopted by reference by the commission in 567—62.4(455B).

b. A standard of performance for a new source promulgated by the administrator under Section 306 of the Act and adopted by reference by the commission in 567—62.4(455B).

c. An effluent standard, effluent prohibition or pretreatment standard promulgated by the administrator under Section 307 of the Act and adopted by reference by the commission in 567—62.4(455B) or 567—62.5(455B).

d. A water quality related effluent limitation established by the administrator pursuant to Section 302 of the Act.

e. Prior to promulgation by the administrator of applicable effluent and pretreatment standards under Sections 301, 302, 306, and 307 of the Act, such conditions as the director determines are necessary to carry out the provisions of the Act.

f. Any other limitation, including those:

(1) Necessary to meet water quality standards, treatment or pretreatment standards, or schedules of compliance established pursuant to any Iowa law or regulation, or to implement the policy of nondegradation in 567—subrule 61.2(2); or

(2) Necessary to meet any other federal law or regulation; or

(3) Required to implement any applicable water quality standards; or

(4) Any legally applicable requirement necessary to implement total maximum daily loads established pursuant to Section 303(d) of the Act and incorporated in the continuing planning process approved under Section 303(e) of the Act and any regulations and guidelines issued pursuant thereto.

g. Any more stringent legally applicable requirements necessary to comply with a plan approved pursuant to Section 208(b) of the Act.

In any case where an NPDES permit applies to effluent standards and limitations described in paragraph *"a," "b," "c," "d," "e," "f,"* or *"g,"* the director must state that the discharge authorized by the permit will not violate applicable water quality standards and must have prepared some verification of that statement. In any case where an NPDES permit applies any more stringent effluent limitation, described in 64.7(2)*"f"*(1), based upon applicable water quality standards, a waste load allocation must be prepared to ensure that the discharge authorized by the permit is consistent with applicable water quality standards.

64.7(3) *Effluent limitations in issued NPDES permits.* In the application of effluent standards, and limitations, water quality standards, and other legally applicable requirements, pursuant to 64.7(2), the director shall, for each issued NPDES permit, specify average and maximum daily quantitative limitations for the level of pollutants in the authorized discharge in terms of weight (except pH, temperature, radiation, and any other pollutants not appropriately expressed by weight). The director may, in addition to the specification of daily quantitative limitations by weight, specify other limitations such as average or maximum concentration limits, for the level of pollutants authorized in the discharge.

[COMMENT. The manner in which effluent limitations are expressed will depend upon the nature of the discharge. Continuous discharges shall be limited by daily loading figures and, where appropriate, may be limited as to concentration or discharge rate (e.g., for toxic or highly variable continuous discharges). Batch discharges should be more particularly described and limited in terms of (i) frequency (e.g., to occur not more than once every three weeks), (ii) total weight (e.g., not to exceed 300 pounds per batch discharge), (iii) maximum rate of discharge of pollutants during the batch discharge (e.g., not to exceed 2 pounds per minute), and (iv) prohibition or limitation by weight, concentration, or other appropriate measure of specified pollutants (e.g., shall not contain at any time more than 0.1 ppm zinc or more than ¼ pound of zinc in any batch discharge). Other intermittent discharges, such as recirculation blowdown, should be particularly limited to comply with any applicable water quality standards and effluent standards and limitations.]

64.7(4) *Schedules of compliance in issued NPDES permits.* The director shall follow the following procedure in setting schedules in NPDES permit conditions to achieve compliance with applicable effluent standards and limitations, water quality standards, and other legally applicable requirements.

a. With respect to any discharge which is not in compliance with applicable effluent standards and limitations, applicable water quality standards, or other legally applicable requirements listed in 64.7(2)*"f"* and 64.7(2)*"g,"* the permittee shall be required to take specific steps to achieve compliance with: applicable effluent standards and limitations; if more stringent, water quality standards; or if more stringent, legally applicable requirements listed in 64.7(2)*"f"* and 64.7(2)*"g."* In the absence of any legally applicable schedule of compliance, such steps shall be achieved in the shortest, reasonable period of time, such period to be consistent with the guidelines and requirements of the Act.

b. In any case where the period of time for compliance specified in paragraph *"a"* of this subrule exceeds nine months, a schedule of compliance shall be specified in the permit which will set forth interim requirements and the dates for their achievement; in no event shall more than nine months elapse between interim dates. If the time necessary for completion of the interim requirements (such as the construction of a treatment facility) is more than nine months and is not readily divided into stages for completion, interim dates shall be specified for the submission of reports of progress toward completion of the interim requirement.

[COMMENT. Certain interim requirements such as the submission of preliminary or final plans often require less than nine months and thus a shorter interval should be specified. Other requirements such as the construction of treatment facilities may require several years for completion and may not readily subdivide into nine-month intervals. Long-term interim requirements should nonetheless be subdivided into intervals not longer than nine months at which the permittee is required to report progress to the director pursuant to 64.7(4)*"c."*]

c. Either before or up to 14 days following each interim date and the final date of compliance the permittee shall provide the department with written notice of the permittee's compliance or noncompliance with the interim or final requirement.

d. On the last day of the months of February, May, August, and November the director shall transmit to the regional administrator a list of all instances, as of 30 days prior to the date of such report, of failure or refusal of a permittee to comply with an interim or final requirement or to notify the department of compliance or noncompliance with each interim or final requirement (as required pursuant to paragraph *"b"* of this subrule). Such list shall be available to the public for inspection and copying and shall contain at least the following information with respect to each instance of noncompliance:

(1) Name and address of each noncomplying permittee.

(2) A short description of each instance of noncompliance (e.g., failure to submit preliminary plans, two-week delay in commencement of construction of treatment facility; failure to notify of compliance with interim requirement to complete construction by June 30).

(3) A short description of any actions or proposed actions by the permittee to comply or by the director to enforce compliance with the interim or final requirement.

(4) Any details which tend to explain or mitigate an instance of noncompliance with an interim or final requirement (e.g., construction delayed due to materials shortage, plan approval delayed by objections).

e. If a permittee fails or refuses to comply with an interim or final requirement in an NPDES permit such noncompliance shall constitute a violation of the permit for which the director may, pursuant to 567—Chapters 7 and 60, modify, suspend or revoke the permit or take direct enforcement action.

64.7(5) *Other terms and conditions of issued NPDES permits.* Each issued NPDES permit shall provide for and ensure the following:

a. That all discharges authorized by the NPDES permit shall be consistent with the terms and conditions of the permit; that facility expansions, production increases, or process modifications which result in new or increased discharges of pollutants must be reported by submission of a new NPDES application or, if such discharge does not violate effluent limitations specified in the NPDES permit, by submission to the director of notice of such new or increased discharges of pollutants; that the discharge of any pollutant more frequently than or at a level in excess of that identified and authorized by the permit shall constitute a violation of the terms and conditions of the permit; that if the terms and conditions of a general permit are no longer applicable to a discharge, the applicant shall apply for an individual NPDES permit;

b. That the permit may be modified, suspended or revoked in whole or in part for the causes provided in 64.3(11).

c. That the permittee shall permit the director or the director's authorized representative upon the presentation of credentials:

(1) To enter upon permittee's premises in which an effluent source is located or in which any records are required to be kept under terms and conditions of the permit;

(2) To have access to and copy any records required to be kept under terms and conditions of the permit;

(3) To inspect any monitoring equipment or method required in the permit; or

(4) To sample any discharge of pollutants.

d. That, if the permit is for a discharge from a publicly owned treatment works, the permittee shall provide notice to the director of the following:

(1) One hundred eighty days in advance of any new introduction of pollutants into such treatment works from a source which would be a new source as defined in Section 306 of the Act if such source were discharging pollutants;

(2) Except as specified below, 180 days in advance of any new introduction of pollutants into such treatment works from a source which would be subject to Section 301 of the Act if such source were discharging pollutants. However, the connection of such a source need not be reported if the source contributes less than 50,000 gallons of wastewater per day at the maximum discharge, or less than 5 percent of the organic or hydraulic loading of the treatment facility, or does not contribute toxic materials that may adversely affect the treatment process or any waste that may have an adverse or deleterious impact on the treatment process; and

(3) Sixty days in advance of any substantial change in volume or character of pollutants being introduced into such treatment works by a source introducing pollutants into such works at the time of issuance of the permit.

Such notice shall include information on the quality and quantity of effluent to be introduced into such treatment works and any anticipated impact of such change in the quantity or quality of effluent to be discharged from such publicly owned treatment works.

e. That, if the permit is for a discharge from a publicly owned treatment works, the permittee shall require any industrial user of such treatment works to comply with the requirements of Sections 204(b), 307, and 308 of the Act. As a means of ensuring such compliance, the permittee shall require that each industrial user subject to the requirements of Section 307 of the Act give to the permittee periodic notice (over intervals not to exceed six months) of progress toward full compliance with Section 307 requirements. The permittee shall forward a copy of the notice to the director.

f. That the permittee at all times shall maintain in good working order and operate as efficiently as possible any facilities or systems of control to achieve compliance with the terms and conditions of the permit.

g. That if a toxic effluent standard or prohibition (including any schedule of compliance specified in such effluent standard or prohibition) is established under Section 307(a) of the Act for a toxic pollutant which is present in the permittee's discharge and such standard or prohibition is more stringent than any limitation upon such pollutant in the NPDES permit, the director shall revise or modify the permit in accordance with the toxic effluent standard or prohibition and so notify the permittee.

h. If an applicant for an NPDES permit proposes to dispose of pollutants into wells as part of a program to meet the proposed terms and conditions of an NPDES permit, the director shall specify additional terms and conditions of the issued NPDES permit which shall prohibit the proposed disposal or control the proposed disposal in order to prevent pollution of ground and surface water resources and to protect the public health and welfare. (See rule 567—62.9(455B) which prohibits the disposal of pollutants, other than heat, into wells within Iowa.)

i. That the permittee shall take all reasonable steps to minimize or prevent any discharge in violation of the permit which has a reasonable likelihood of adversely affecting human health or the environment.

j. It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the terms of this permit.

64.7(6) *POTW compliance—plan of action required.* The owner of a publicly owned treatment works (POTW) must prepare and implement a plan of action to achieve and maintain compliance with final effluent limitations in its NPDES permit, as specified below:

a. The director shall notify the owner of a POTW of the plan of action requirement, and of an opportunity to meet with department staff to discuss the plan of action requirements. The POTW owner shall submit a plan of action within six months of such notice, unless a longer time is needed and is authorized in writing by the director.

b. The plan of action will vary in length and complexity depending on the compliance history and physical status of the particular POTW. It must identify the deficiencies and needs of the system, describe the causes of such deficiencies or needs, propose specific measures (including an implementation schedule) that will be taken to correct the deficiencies or meet the needs, and discuss the method of financing the improvements proposed in the plan of action.

The plan may provide for a phased construction approach to meet interim and final limitations, where financing is such that a long-term project is necessary to meet final limitations, and shorter term projects may provide incremental benefits to water quality in the interim.

Information on the purpose and preparation of the plan can be found in the departmental document entitled "Guidance on Preparing a Plan of Action," available through the records center of the department.

c. Upon submission of a complete plan of action to the department, the plan should be reviewed and approved or disapproved within 60 days unless a longer time is required and the POTW owner is so notified.

d. The NPDES permit for the facility shall be amended to include the implementation schedule or other actions developed through the plan to achieve and maintain compliance.

This rule is intended to implement Iowa Code chapter 455B, division III, part 1 (455B.171 to 455B.187).

567—64.8(455B) Reissuance of NPDES permits.

64.8(1) *Individual NPDES permits.* Individual NPDES permits will be reissued according to the procedures identified in 64.8(1)*"a"* to *"c."*

a. Any state NPDES permittee who wishes to continue to discharge after the expiration date of the permit shall file an application for reissuance of the permit at least 180 days prior to the expiration of the permit. The application may be a simple written request. However, the applicant for reissuance must submit or have submitted information to show:

(1) That the permittee is in compliance or has substantially complied with all the terms, conditions, requirements and schedules of compliance of the expiring NPDES permit.

(2) Up-to-date information on the permittee's production levels, permittee's waste treatment practices, nature, contents, and frequency of permittee's discharge.

(3) That the discharge is consistent with applicable effluent standards and limitations, water quality standards and other legally applicable requirements listed in 64.7(2), including any additions to, or revision or modifications of, such effluent standards and limitations, water quality standards, or other legally applicable requirements during the term of the permit.

b. The director shall follow the notice and public participation procedures specified in 64.5(455B) in connection with each request for reissuance of an NPDES permit.

c. Notwithstanding any other provision in these rules, any new point source the construction of which is commenced after the date of enactment of the Federal Water Pollution Control Act Amendments of 1972 (October 18, 1972) and which is so constructed as to meet all applicable standards of performance for new sources shall not be subject to any more stringent standard of performance during a ten-year period beginning on the date of completion of such construction or during the period of depreciation or amortization of such facility for the purposes of Section 167 or 169 (or both) of the Internal Revenue Code, as amended through December 31, 1976, whichever period ends first.

64.8(2) *Renewal of coverage under a general permit.* Coverage under a general permit will be renewed subject to the terms and conditions in paragraphs *"a"* to *"d."*

a. If a permittee intends to continue an activity covered by a general permit beyond the expiration date of the general permit, the permittee must reapply and submit a complete Notice of Intent as follows:

(1) For storm water discharge associated with industrial activity, complete Notice of Intent requirements are listed in 64.6(1).

(2) Reserved.

b. A complete Notice of Intent for coverage under a reissued or renewed general permit must be submitted to the department within 180 days after the expiration date of a general permit.

c. A person holding a general permit is subject to the terms of the permit until it expires or a Notice of Discontinuation is submitted in accordance with 64.6(5). If the person holding a general permit continues the activity beyond the expiration date, the conditions of the expired general permit will remain in effect provided the permittee submits a complete Notice of Intent for coverage under a renewed or reissued general permit 180 days after the expiration date of the expired general permit. If the person continues an activity for which the general permit has expired and the general permit has not been reissued or renewed the discharge must be permitted with an individual NPDES permit according to the procedures in 64.3(4)*"a."*

d. The Notice of Intent requirements shall not include a public notification when a general permit has been reissued or renewed provided the permittee has already submitted a complete Notice of Intent including the public notification requirements of 64.6(1). Another public notice is required when any information, including facility location, in the original public notice is changed.

567—64.9(455B) Monitoring, record keeping and reporting by operation permit holders. Operation permit holders are subject to any applicable requirements specified in 567—Chapter 63.

567—64.10(455B) Silvicultural activities. The following is adopted by reference: 40 CFR 122.27 as promulgated April 1, 1983 (48 FR 14153).

567—64.11 and **64.12** Reserved.

567—64.13(455B) Storm water discharges.

64.13(1) The following is adopted by reference: 40 CFR 122.26 as promulgated November 16, 1990 (55 FR 47990), and amended March 21, 1991 (56 FR 12098), April 2, 1992 (57 FR 11394), and December 8, 1999 (64 FR 68838).

64.13(2) Small municipal separate storm sewer systems.

a. For any discharge from a regulated small municipal separate storm sewer system (MS4), the permit application must be submitted no later than March 10, 2003, if designated under this subrule.

b. All MS4s located in urbanized areas as defined by the latest decennial census and all MS4s which serve 10,000 people or more located outside urbanized areas and where the average population density is 1,000

people/square mile or more are regulated small MS4s unless waiver criteria established by the department are met and a waiver has been granted by the department.

c. Permit coverage requirements for MS4s located in urbanized areas and serving 1,000 or more people and fewer than 10,000 people may be waived if the following requirements are met:

(1) The department has evaluated all waters of the United States that receive a discharge from the MS4, and for all such waters, the department has determined that storm water controls are not needed based on wasteload allocations that are part of an EPA approved or established total maximum daily load (TMDL) that addresses the pollutants of concern or, if a TMDL has not been developed or approved, an equivalent analysis that determines sources and allocations for the pollutants of concern. The pollutants of concern include biochemical oxygen demand, sediment or a parameter that addresses sediment (total suspended solids, turbidity or siltation), pathogens, oil and grease, and any pollutant that has been identified as a cause of impairment of any water body that will receive a discharge from the MS4.

(2) The department has determined that future discharges from the MS4 do not have the potential to result in exceedances of water quality standards, including impairment of designated uses or other significant water quality impacts including habitat and biological impacts.

d. Permit coverage requirements for MS4s located in urbanized areas and serving fewer than 1,000 people may be waived if the following requirements are met:

(1) The system is not contributing substantially to the pollutant loadings of a physically interconnected MS4 that is regulated by the NPDES storm water program.

(2) The MS4 discharges any pollutants that have been identified as a cause of impairment of any water body to which the MS4 discharges and the department has determined that storm water controls are not needed based upon wasteload allocations that are a part of an EPA approved or established TMDL that addresses the pollutants of concern.

e. Permit coverage requirements for MS4s located outside of urbanized areas and serving 10,000 or more people may be waived if the following criterion is met:

The MS4 is not discharging pollutants which are the cause of the impairment to a water body designated by the department as impaired.

f. Should conditions under which the initial waiver was granted change, the waiver may be rescinded by the department and permit coverage may be required.

g. MS4 applications shall, at a minimum, demonstrate in what manner the applicant will develop, implement and enforce a storm water management program designed to reduce the discharge of pollutants from the MS4 to the maximum extent practicable, to protect water quality and to satisfy the appropriate water quality requirements of the Clean Water Act. The manner in which the permittee will address the following items must be addressed in the application: public education and outreach on storm water impacts, public involvement and participation, illicit discharge detection and elimination, construction site storm water runoff control, postconstruction storm water management in new development and redevelopment, and pollution prevention for municipal operations. Measurable goals which the applicant intends to meet and dates by which the goals will be accomplished shall be included with the application.

64.13(3) Waivers for storm water discharge associated with small construction activity. The director may waive the otherwise applicable requirements in a general permit for storm water discharge from small construction activities as defined in 567—Chapter 60 when:

a. The value of the rainfall erosivity factor ("R" in the Revised Universal Soil Loss Equation) is less than 5 during the period of construction activity. The rainfall erosivity factor is determined in accordance with Chapter 2 of Agriculture Handbook Number 703, Predicting Soil Erosion by Water: A Guide to Conservation Planning With the Revised Universal Soil Loss Equation (RUSLE), pages 21-64, dated January 1997; or

b. Storm water controls are not needed based on a TMDL approved or established by the EPA that addresses the pollutant(s) of concern or, for nonimpaired waters that do not require TMDLs, an equivalent analysis that determines allocations for small construction sites for the pollutant(s) of concern or that determines that such allocations are not needed to protect water quality based on consideration of existing in-stream concentrations, expected growth in pollutant contributions from all sources, and a margin of safety. The pollutant(s) of concern includes sediment or a parameter that addresses sediment (such as total suspended solids, turbidity or siltation) and any other pollutant that has been identified as a cause of impairment of any water body that will receive a discharge from the construction activity.

567—64.14(455B) Transfer of title. If title to any disposal system or part thereof for which a permit has been issued under 64.2(455B), 64.3(455B) or 64.6(455B) is transferred, the new owners shall be subject to all terms and conditions of said permit. Whenever title to a disposal system or part thereof is changed, the department shall be notified of such change within 30 days.

Rules 567—64.3(455B) to 64.14(455B) are intended to implement Iowa Code section 455B.173.

567—64.15(455B) General permits issued by the department. The following is a list of general permits adopted by the department through the Administrative Procedure Act, Iowa Code chapter 17A, and the term of each permit.

64.15(1) Storm Water Discharge Associated with Industrial Activity, NPDES General Permit No. 1, effective October 1, 2007, to October 1, 2012. Facilities assigned Standard Industrial Classification 1442, 2951, or 3273, and those facilities assigned Standard Industrial Classification 1422 or 1423 which are engaged primarily in rock crushing are not eligible for coverage under General Permit No. 1.

64.15(2) Storm Water Discharge Associated with Industrial Activity for Construction Activities, NPDES General Permit No. 2, effective October 1, 2007, to October 1, 2012.

a. Part I, provision B, section 1, paragraph A of General Permit No. 2 is amended to read as follows:

Except for discharges identified under Parts I.B.2. and I.B.3., this permit may authorize the discharge of storm water associated with industrial activity from construction sites, (those sites or common plans of development or sale that will result in the disturbance of one or more acres of total land area),

b. Part VIII, under the definition: Storm water discharge associated with industrial activity, paragraph (x) of General Permit No. 2 is amended to read as follows:

Construction activity including clearing, grading and excavation activities except: operations that result in the disturbance of less than one acre of total land area which is not part of a larger common plan of development or sale.

64.15(3) Storm Water Discharge Associated with Industrial Activity from Asphalt Plants, Concrete Batch Plants, Rock Crushing Plants, and Construction Sand and Gravel Facilities, NPDES General Permit No. 3, effective October 1, 2007, to October 1, 2012. General Permit No. 3 authorizes storm water discharges from facilities primarily engaged in manufacturing asphalt paving mixtures and which are classified under Standard Industrial Classification 2951, primarily engaged in manufacturing Portland cement concrete and which are classified under Standard Industrial Classification 3273, those facilities assigned Standard Industrial Classification 1422 or 1423 which are primarily engaged in the crushing, grinding or pulverizing of limestone or granite, and construction sand and gravel facilities which are classified under Standard Industrial Classification 1442. General Permit No. 3 does not authorize the discharge of water resulting from dewatering activities at rock quarries.

64.15(4) "Discharge from Onsite Wastewater Treatment and Disposal Systems," NPDES General Permit No. 4, effective January 1, 2004, to December 31, 2008.

64.15(5) "Discharge from Mining and Processing Facilities," NPDES General Permit No. 5, effective July 18, 2001.

567—64.16(455B) Fees.

64.16(1) A person who applies for an individual permit or coverage under a general permit to construct, install, modify or operate a disposal system shall submit along with the application an application fee or a permit fee or both as specified in 64.16(3). Certain individual facilities shall also be required to submit annual fees as specified in 64.16(3)*"b."* Fees shall be assessed based on the type of permit coverage the applicant requests, either as general permit coverage or as an individual permit. For a construction permit, an application fee must be submitted with the application. For General Permits Nos. 1, 2, 3 and 5, the applicant has the option of paying an annual permit fee or a multiyear permit fee at the time the Notice of Intent for coverage is submitted.

For individual storm water only permits, a one-time, multiyear permit fee must be submitted at the time of application. A storm water only permit is defined as an NPDES permit that authorizes the discharge of only storm water and any allowable non-storm water as defined in the permit. For all other non-storm water NPDES permits and operation permits, the applicant must submit an application fee at the time of application and the appropriate annual fee on a yearly basis. A non-storm water NPDES permit is defined as any individual NPDES permit or operation permit issued to a municipality, industry, semipublic entity, or animal feeding operation that is not an individual storm water only permit. If a facility needs coverage under more than one NPDES permit, fees for each permit must be submitted appropriately.

Fees are nontransferable. If the application is returned to the applicant by the department, the permit fee will be returned. No fees will be returned if the permit or permit coverage is suspended, revoked, or modified, or if the activity is discontinued. Failure to submit the appropriate fee at the time of application renders the application incomplete, and the department shall suspend processing of the application until the fee is received. Failure to submit the appropriate annual fee may result in revocation or suspension of the permit as noted in 64.3(11)*"f."*

64.16(2) Payment of fees. Fees shall be paid by check or money order made payable to the "Iowa Department of Natural Resources."

For facilities needing coverage under both a storm water only permit and a non-storm water NPDES permit, separate payments shall be made according to the fee schedule in 64.16(3).

64.16(3) Fee schedule. The following fees have been adopted:

a. For coverage under the NPDES general permits, the following fees apply:

(1) Storm Water Discharges Associated with Industrial Activity, NPDES General Permit No. 1.

Annual Permit Fee . . . . . $175(per year)

or

Five-year Permit Fee. $700
Four-year Permit Fee $525
Three-year Permit Fee $350

All fees are to be submitted with the Notice of Intent for coverage under the general permit.

(2) Storm Water Discharge Associated with Industrial Activity for Construction Activities, NPDES General Permit No. 2. The fees are the same as those specified for General Permit No. 1 in subparagraph (1) of this paragraph.

(3) Storm Water Discharge Associated with Industrial Activity from Asphalt Plants, Concrete Batch Plants, and Rock Crushing Plants, NPDES General Permit No. 3. The fees are the same as those specified for General Permit No. 1 in subparagraph (1) of this paragraph.

(4) Discharge from Onsite Wastewater Treatment and Disposal Systems, NPDES Permit No. 4. No fees shall be assessed.

(5) Discharge from Mining and Processing Facilities, NPDES General Permit No. 5. Fees as established in 2006 Iowa Acts, House File 2540, section 25, are to be submitted by August 30 of every year unless a multiyear fee payment was received in an earlier year. New facilities seeking General Permit No. 5 coverage in any month but August shall submit fees with the Notice of Intent for coverage. Coverage provided by the five-year, four-year, or three-year permit fees expires no later than the expiration date of the general permit. Maximum coverage is five years, four years, and three years, respectively. In the event a facility is no longer eligible to be covered under General Permit No. 5, the remainder of the fees previously paid by the facility shall be applied toward its individual permit fees.

b. Individual NPDES and operation permit fees. The following fees are applicable for the described individual NPDES permit:

(1) For permits that authorize the discharge of only storm water associated with industrial activity and any allowable non-storm water, a five-year permit fee of $1,250 must accompany the application.

(2) For permits that authorize the discharge of only storm water from municipal separate storm sewer systems and any allowable non-storm water, a five-year permit fee of $1,250 must accompany the application.

(3) For permits not subject to subparagraphs (1) and (2), a single application fee of $85 as established in 2006 Iowa Acts, House File 2540, section 25, is due at the time of application. The application fee is to be submitted with the application form (Form 30 for municipal and semipublic facilities; Form 1, 2, 2F, 3, or 4 for industrial facilities) at the time of a new application, renewal application, or amendment application. Before an approved amendment request submitted by a facility holding a non-storm water NPDES permit can be processed by the department, the application fee must be submitted. Application fees will not be charged to facilities holding non-storm water NPDES permits when an amendment request is submitted by DNR staff, or when the requested amendment is to correct an error in the permit.

(4) For every major and minor municipal facility, every semipublic facility, every major and minor industrial facility, every facility that holds an operation permit (no wastewater discharge into surface waters), and every open feedlot animal feeding operation required to hold a non-storm water NPDES permit, an annual fee as established in 2006 Iowa Acts, House File 2540, section 25, is due by August 30 of each year.

(5) For every municipal water treatment facility with a non-storm water NPDES permit, no fee is charged (as established in 2006 Iowa Acts, House File 2540, section 25).

(6) For a new facility, an annual fee as established in 2006 Iowa Acts, House File 2540, section 25, is due 30 days after the new permit is issued.

c. Wastewater construction permit fees. A single construction permit fee as established in 2006 Iowa Acts, House File 2540, section 25, is due at the time of construction permit application submission.

64.16(4) Fee refunds for storm water general permit coverage—pilot project. Rescinded IAB 10/16/02, effective 11/20/02.

567—64.17(455B) Validity of rules. If any section, paragraph, sentence, clause, phrase or word of these rules, or any part thereof, be declared unconstitutional or invalid for any reason, the remainder of said rules shall not be affected thereby and shall remain in full force and effect.

567—64.18(455B) Applicability. This chapter shall apply to all waste disposal systems treating or intending to treat sewage, industrial waste, or other waste except waste resulting from livestock or poultry operations. All livestock and poultry operations constituting animal feeding operations as defined in 567—Chapter 65 shall be governed by the requirements contained in Chapter 65. However, if an animal feeding operation is required to apply for and obtain an NPDES permit, the provisions of this chapter relating to notice and public participation, to the terms and conditions of the permit, to the reissuance of the permit and to monitoring, reporting and record-keeping activities shall apply.

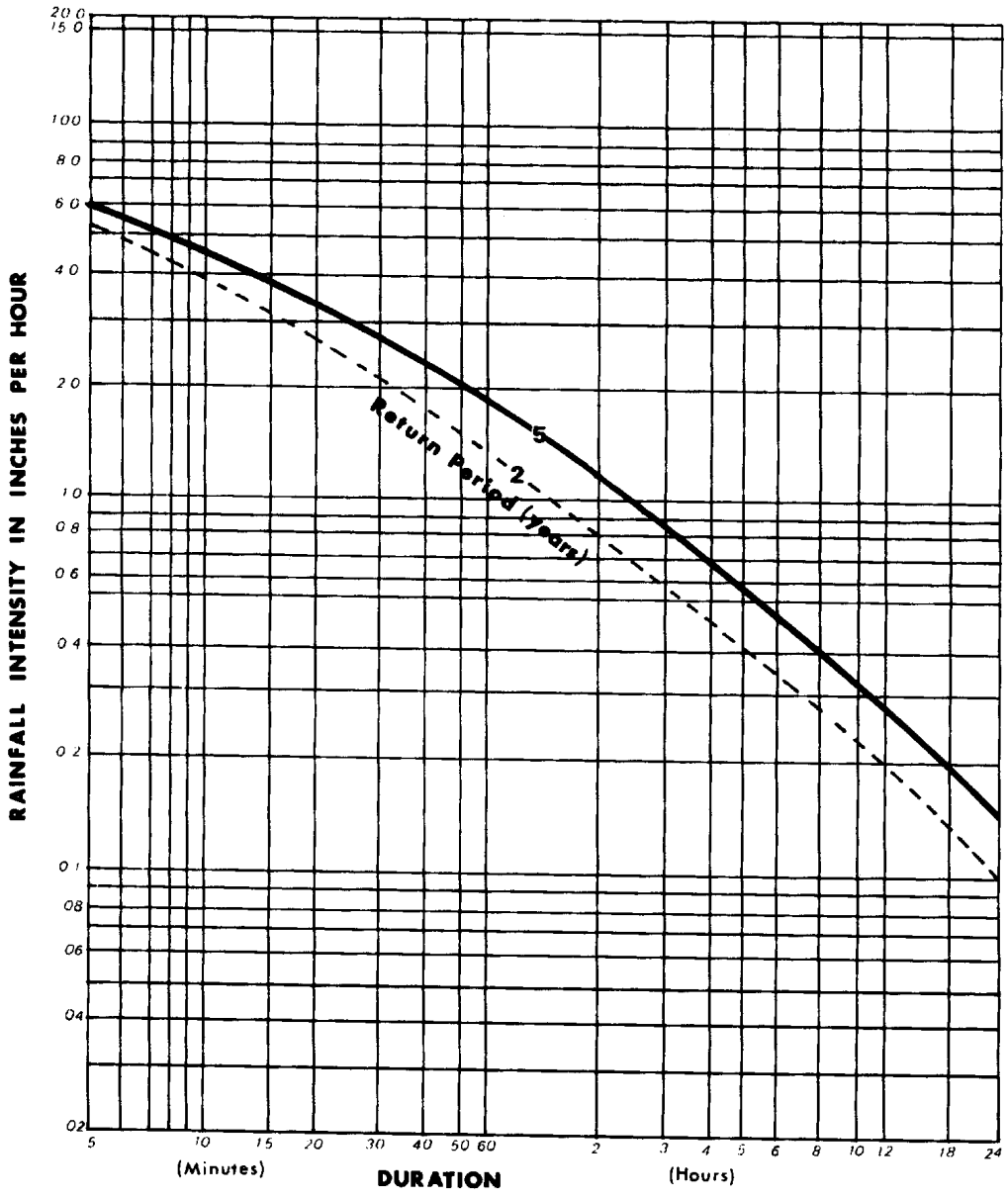
These rules are intended to implement Iowa Code chapter 455B, division III, part 1.

[Filed August 21, 1973]
[Filed 6/28/76, Notice 5/3/76—published 7/12/76, effective 8/16/76]
[Filed 7/1/77, Notice 3/23/77—published 7/27/77, effective 8/31/77]
[Filed emergency 7/28/77—published 8/24/77, effective 8/31/77]
[Filed emergency 2/3/78—published 2/22/78, effective 3/1/78]
[Filed 10/13/78, Notice 5/3/78—published 11/1/78, effective 12/6/78]
[Filed 3/30/79, Notice 2/7/79—published 4/18/79, effective 5/23/79]
[Filed 5/11/79, Notice 2/7/79—published 5/30/79, effective 7/5/79]
[Filed 8/3/79, Notice 5/2/79—published 8/22/79, effective 9/26/79]
[Filed 8/31/79, Notice 4/4/79—published 9/19/79, effective 10/24/79]
[Filed 4/10/80, Notice 12/26/79—published 4/30/80, effective 6/4/80]
[Filed 11/3/80, Notices 6/25/80, 8/20/80—published 11/26/80, effective 12/31/80, 7/1/81]
[Filed 10/23/81, Notice 5/13/81—published 11/11/81, effective 12/16/81]
[Filed 9/24/82, Notice 7/21/82—published 10/13/82, effective 11/17/82]
[Filed 2/24/83, Notice 11/10/82—published 3/16/83, effective 4/20/83]
[Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]
[Filed 9/23/83, Notice 7/20/83—published 10/12/83, effective 11/16/83]
[Filed 12/2/83, Notice 6/22/83—published 12/21/83, effective 1/25/84]
[Filed 5/31/84, Notice 1/4/84—published 6/20/84, effective 7/25/84]
[Filed 12/28/84, Notice 11/7/84—published 1/16/85, effective 2/20/85]
[Filed 3/22/85, Notice 1/16/85—published 4/10/85, effective 5/15/85]
[Filed 11/1/85, Notice 6/19/85—published 11/20/85, effective 12/25/85]
[Filed 2/21/86, Notices 9/11/85, 11/20/85—published 3/12/86, effective 4/16/86]
[Filed 5/30/86, Notice 11/20/85—published 6/18/86, effective 7/23/86]
[Filed 5/30/86, Notice 3/12/86—published 6/18/86, effective 7/23/86][1]
[Filed emergency 11/14/86—published 12/3/86, effective 12/3/86]
[Filed 11/14/86, Notice 5/21/86—published 12/3/86, effective 1/7/87]
[Filed 5/29/87, Notice 3/11/87—published 6/17/87, effective 7/22/87]
[Filed 6/19/92, Notice 12/11/91—published 7/8/92, effective 8/12/92]

[Filed 10/24/97, Notice 7/16/97—published 11/19/97, effective 12/24/97]
[Filed 3/19/98, Notice 11/19/97—published 4/8/98, effective 5/13/98]
[Filed 10/28/99, Notice 5/19/99—published 11/17/99, effective 12/22/99]
[Filed emergency 7/21/00—published 8/9/00, effective 7/21/00]
[Filed 3/2/01, Notice 8/9/00—published 3/21/01, effective 4/25/01]
[Filed 5/25/01, Notice 3/21/01—published 6/13/01, effective 7/18/01]
[Filed 7/25/02, Notice 5/15/02—published 8/21/02, effective 10/1/02]
[Filed 9/25/02, Notice 7/10/02—published 10/16/02, effective 11/20/02]
[Filed emergency 12/17/02—published 1/8/03, effective 12/17/02]
[Filed 11/19/03, Notice 6/11/03—published 12/10/03, effective 1/14/04]
[Filed emergency 4/21/06—published 5/10/06, effective 4/21/06]
[Filed 6/28/06, Notice 11/9/05—published 7/19/06, effective 8/23/06]
[Filed emergency 7/28/06—published 8/16/06, effective 8/23/06]
[Filed 3/8/07, Notice 1/3/07—published 3/28/07, effective 5/2/07]
[Filed 6/14/07, Notice 2/28/07—published 7/4/07, effective 10/1/07]
[Filed 6/12/08, Notice 1/2/08—published 7/2/08, effective 8/6/08]

[1] Effective date of 64.2(9)*"c"* delayed 70 days by the Administrative Rules Review Committee. The 70-day delay of effective date of 64.2(9)*"c"* was lifted by the Administrative Rules Review Committee on 7/31/86.

RAINFALL INTENSITY - DURATION - FREQUENCY CURVES
Appendix A



CHAPTER 135
TECHNICAL STANDARDS AND CORRECTIVE ACTION REQUIREMENTS FOR OWNERS AND OPERATORS OF UNDERGROUND STORAGE TANKS

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—135.1(455B) Authority, purpose and applicability.

135.1(1) *Authority.* Iowa Code chapter 455B, division IV, part 8, authorizes the department to regulate underground tanks used for storage of regulated substances, and to adopt rules relating to detection, prevention and correction of releases of regulated substances from such tanks, maintenance of financial responsibility by owners or operators of such tanks, new tank performance standards, notice and reporting requirements, and designation of regulated substances.

135.1(2) *Purpose.* The purpose of these rules is to protect the public health and safety and the natural resources of Iowa by timely and appropriate detection, prevention and correction of releases of regulated substances from underground storage tanks (UST).

135.1(3) *Applicability.*

a. The requirements of this chapter apply to all owners and operators of a UST system as defined in 135.2(455B) except as otherwise provided in paragraphs *"b," "c,"* and *"d"* of this subrule. Any UST system listed in paragraph *"c"* of this subrule must meet the requirements of 135.1(4).

b. The following UST systems are excluded from the requirements of this chapter:

(1) Any UST system holding hazardous wastes listed or identified under Subtitle C of the Solid Waste Disposal Act, or a mixture of such hazardous waste and other regulated substances.

(2) Any wastewater treatment tank system that is part of a wastewater treatment facility regulated under Section 402 or 307(b) of the federal Clean Water Act.

(3) Equipment or machinery that contains regulated substances for operational purposes such as hydraulic lift tanks and electrical equipment tanks.

(4) Any UST system whose capacity is 110 gallons or less.

(5) Any UST system that contains a de minimus concentration of regulated substances.

(6) Any emergency spill or overflow containment UST system that is expeditiously emptied after use.

c. Deferrals. Rules 135.3(455B), 135.4(455B), 135.5(455B), 135.6(455B) and 135.9(455B) do not apply to any of the following types of UST systems:

(1) Wastewater treatment tank systems;

(2) Any UST systems containing radioactive material that are regulated under the federal Atomic Energy Act of 1954 (42 U.S.C. 2011 and following);

(3) Any UST system that is part of an emergency generator system at nuclear power generation facilities regulated by the Nuclear Regulatory Commission under 10 CFR 50 Appendix A;

(4) Airport hydrant fuel distribution systems; and

(5) UST systems with field-constructed tanks.

d. Deferrals. Rule 135.5(455B) does not apply to any UST system that stores fuel solely for use by emergency power generators. All new and replacement UST systems for emergency power generators must meet the secondary containment requirements in subrule 135.3(9) and the leak detection and delivery prohibition requirements in subrule 135.3(8).

e. Nonpetroleum underground storage tank systems. Rules 135.8(455B) to 135.12(455B) do not apply to any nonpetroleum underground storage tank system except as otherwise provided for by the department.

135.1(4) *Interim prohibition for deferred UST systems.*

a. No person may install a UST system listed in 135.1(3)*"c"* for the purpose of storing regulated substances unless the UST system (whether of single- or double-wall construction):

(1) Will prevent releases due to corrosion or structural failure for the operational life of the UST system;

(2) Is cathodically protected against corrosion, constructed of noncorrodible material, steel clad with a noncorrodible material, or designed in a manner to prevent the release or threatened release of any stored substance; and

(3) Is constructed or lined with material that is compatible with the stored substance.

b. Notwithstanding paragraph *"a"* of this subrule, a UST system without corrosion protection may be installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due

to corrosion during its operating life. Owners and operators must maintain records that demonstrate compliance with the requirements of this paragraph for the remaining life of the tank.

NOTE: The National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," may be used as guidance for complying with 135.1(4)*"b."*

567—135.2(455B) Definitions.

"Aboveground release" means any release to the surface of the land or to surface water. This includes, but is not limited to, releases from the aboveground portion of a UST system and aboveground releases associated with overfills and transfer operations as the regulated substance moves to or from a UST system.

"Active remediation" means corrective action undertaken to reduce contaminant concentrations by other than passive remediation or monitoring.

"Ancillary equipment" means any devices including, but not limited to, such devices as piping, fittings, flanges, valves, and pumps used to distribute, meter, or control the flow of regulated substances to and from a UST.

"Appurtenances" means devices such as piping, fittings, flanges, valves, dispensers and pumps used to distribute, meter, or control the flow of regulated substances to or from an underground storage tank.

"ASTM" means the American Society of Testing and Materials.

"Bedrock" means the rock, usually solid, underlying soil or any other unconsolidated surficial cover.

"Below-ground release" means any release to the subsurface of the land and to groundwater. This includes, but is not limited to, releases from the below-ground portions of an underground storage tank system and below-ground releases associated with overfills and transfer operations as the regulated substance moves to or from an underground storage tank.

"Beneath the surface of the ground" means beneath the ground surface or otherwise covered with earthen materials.

"Best available technology" means those practices which most appropriately remove, treat, or isolate contaminants from groundwater, soil or associated environment, as determined through professional judgment considering actual equipment or techniques currently in use, published technical articles, site hydrogeology and research results, engineering and groundwater professional reference materials, consultation with experts in the field, capital and operating costs, and guidelines or rules of other regulatory agencies.

"Best management practices" means maintenance procedures, schedule of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment, is determined to be the most effective means of monitoring and preventing additional contamination of the groundwater and soil.

"Carcinogenic risk" means the incremental risk of a person developing cancer over a lifetime as a result of exposure to a chemical, expressed as a probability such as one in a million (10^{-6}). For carcinogenic chemicals of concern, probability is derived from application of certain designated exposure assumptions and a slope factor.

"Cathodic protection" is a technique to prevent corrosion of a metal surface by making that surface the cathode of an electrochemical cell. For example, a tank system can be cathodically protected through the application of either galvanic anodes or impressed current.

"Cathodic protection tester" means a person who can demonstrate an understanding of the principles and measurements of all common types of cathodic protection systems as applied to buried or submerged metal piping and tank systems. At a minimum, such persons must have education and experience in soil resistivity, stray current, structure-to-soil potential, and component electrical isolation measurements of buried metal piping and tank systems.

"CERCLA" means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

"Certified groundwater professional" means a person certified pursuant to 1995 Iowa Code section 455G.18 and 567—Chapter 134.

"Change-in-service" means changing the use of a tank system from a regulated to a nonregulated use.

"Chemicals of concern" means the compounds derived from petroleum-regulated substances which are subject to evaluation for purposes of applying risk-based corrective action decision making. These compounds are benzene, ethylbenzene, toluene, and xylenes (BTEX) and naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. (NOTE: Measurement of these last four constituents may be done by a conversion method from total extractable hydrocarbons, see subrule 135.8(3).)

"Compatible" means the ability of two or more substances to maintain their respective physical and chemical properties upon contact with one another for the design life of the tank system under conditions likely to be encountered in the UST.

"Conduit" means underground structures which act as pathways and receptors for chemicals of concern, including but not limited to gravity drain lines and sanitary or storm sewers.

"Connected piping" means all underground piping including valves, elbows, joints, flanges, and flexible connectors attached to a tank system through which regulated substances flow. For the purpose of determining how much piping is connected to any individual UST system, the piping that joins two UST systems should be allocated equally between them.

"Consumptive use" with respect to heating oil means consumed on the premises.

"Corrective action" means an action taken to reduce, minimize, eliminate, clean up, control or monitor a release to protect the public health and safety or the environment. Corrective action includes, but is not limited to, excavation of an underground storage tank for the purpose of repairing a leak or removal of a tank, removal of contaminated soil, disposal or processing of contaminated soil, cleansing of groundwaters or surface waters, natural biodegradation, institutional controls, technological controls and site management practices. Corrective action does not include replacement of an underground storage tank. Corrective action specifically excludes third-party liability.

"Corrective action meeting process" means a series of meetings organized by department staff with owners or operators and other interested parties such as certified groundwater professionals, funding source representatives, and affected property owners. The purpose of the meeting process is to develop and agree on a corrective action plan and the terms for implementation of the plan.

"Corrective action plan" means a plan which specifies the corrective action to be undertaken by the owner or operator in order to comply with requirements in this chapter and which is incorporated into a memorandum of agreement or other written agreement between the department and the owner or operator. The plan may include but is not limited to provisions for additional site assessment, site monitoring, Tier 2 revisions, Tier 3 assessment, excavation, and other soil and groundwater remedial action.

"Corrosion expert" means a person who, by reason of thorough knowledge of the physical sciences and the principles of engineering and mathematics acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person must be accredited or certified as being qualified by the National Association of Corrosion Engineers or be a registered professional engineer who has certification or licensing that includes education and experience in corrosion control of buried or submerged metal piping systems and metal tanks.

"Department" means Iowa department of natural resources.

"Dielectric material" means a material that does not conduct direct electrical current. Dielectric coatings are used to electrically isolate UST systems from the surrounding soils. Dielectric bushings are used to electrically isolate portions of the UST systems (e.g., tank from piping).

"Dispenser" means equipment that is used to transfer a regulated substance from underground piping through a rigid or flexible hose or piping located aboveground to a point of use outside the underground storage tank system, such as a motor vehicle.

"Drinking water well" means any groundwater well used as a source for drinking water by humans and groundwater wells used primarily for the final production of food or medicine for human consumption in facilities routinely characterized with the Standard Industrial Codes (SIC) group 283 for drugs and 20 for foods.

"Electrical equipment" means underground equipment that contains dielectric fluid that is necessary for the operation of equipment such as transformers and buried electrical cable.

"Enclosed space" means space which can act as a receptor or pathway capable of creating a risk of explosion or inhalation hazard to humans and includes "explosive receptors" and "confined spaces." Explosive receptors means those receptors designated in these rules which are evaluated for explosive risk. Confined spaces means those receptors designated in these rules for evaluation of vapor inhalation risks.

"Excavation zone" means the volume containing the tank system and backfill material bounded by the ground surface, walls, and floor of the pit and trenches into which the UST system is placed at the time of installation.

"Existing tank system" means a tank system used to contain an accumulation of regulated substances or for which installation has commenced on or before January 14, 1987. Installation is considered to have commenced if:

The owner or operator has obtained all federal, state, and local approvals or permits necessary to begin physical construction of the site or installation of the tank system; and if,

1. Either a continuous on-site physical construction or installation program has begun; or,
2. The owner or operator has entered into contractual obligations, which cannot be canceled or modified without substantial loss, for physical construction at the site or installation of the tank system to be completed within a reasonable time.

"Farm tank" is a tank located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank must be located on the farm property. "Farm" includes fish hatcheries, rangeland and nurseries with growing operations.

"Flow-through process tank" is a tank that forms an integral part of a production process through which there is a steady, variable, recurring, or intermittent flow of materials during the operation of the process. Flow-through process tanks do not include tanks used for the storage of materials prior to their introduction into the production process or for the storage of finished products or by-products from the production process.

"Free product" refers to a regulated substance that is present as a nonaqueous phase liquid (e.g., liquid not dissolved in water).

"Gathering lines" means any pipeline, equipment, facility, or building used in the transportation of oil or gas during oil or gas production or gathering operations.

"Groundwater ingestion pathway" means a pathway through groundwater by which chemicals of concern may result in exposure to a human receptor as specified in rules applicable to Tier 1, Tier 2 and Tier 3.

"Groundwater plume" means the extent of groundwater impacted by the release of chemicals of concern.

"Groundwater to plastic water line pathway" means a pathway through groundwater which leads to a plastic water line.

"Groundwater vapor to enclosed space pathway" means a pathway through groundwater by which vapors from chemicals of concern may lead to a receptor creating an inhalation or explosive risk hazard.

"Hazardous substance UST system" means an underground storage tank system that contains a hazardous substance defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (but not including any substance regulated as a hazardous waste under subtitle C) or any mixture of such substances and petroleum, and which is not a petroleum UST system.

"Hazard quotient" means the ratio of the level of exposure of a chemical of concern over a specified time period to a reference dose for that chemical of concern derived for a similar exposure period. Unless otherwise specified, the hazard quotient designated in these rules is one.

"Heating oil" means petroleum that is No. 1, No. 2, No. 4-light, No. 4-heavy, No. 5-light, No. 5-heavy, and No. 6 technical grades of fuel oil; other residual fuel oils (including Navy Special Fuel Oil and Bunker C); and other fuels when used as substitutes for one of these fuel oils. Heating oil is typically used in the operation of heating equipment, boilers, or furnaces.

"Highly permeable soils" means for the purpose of UST closures: fractured bedrock, any soils with a hydraulic conductivity rate greater than 0.3 meters per day, or any soil material classified by the Unified Soil Classification System as published by the United States Department of the Interior or ASTM designation as (1) GW - well graded gravel, gravel-sand mixtures, little or no fines, (2) GP - poorly graded gravel, gravel-sand mixtures, little or no fines, (3) SW - well graded sands, gravelly sands, little or no fines, or (4) SP - poorly graded sands, gravelly sands, little or no fines.

"Hydraulic conductivity" means the rate of water movement through the soil measured in meters per day (m/d) as determined by the following methods. For a saturated soil, the Bouwer-Rice method or its equivalent shall be used. For unsaturated soil, use a Guelph permeameter or an equivalent in situ constant-head permeameter in a boring finished above the water table. If an in situ method cannot be used for unsaturated soil because of depth, or if the soil is homogeneous and lacks flow-conducting channels, fractures, cavities, etc., laboratory measurement of hydraulic conductivity is acceptable.

If laboratory methods are used, collect undisturbed soil samples using a thin-walled tube sampler in accordance with American Society of Testing and Materials (ASTM) Standard D1587. Samples shall be clearly marked, preserved and transported to the laboratory. The laboratory shall measure hydraulic conductivity using a constant-head permeameter in accordance with ASTM Standard D2434 or a falling-head permeameter in accordance with accepted methodology.

"Hydraulic lift tank" means a tank holding hydraulic fluid for a closed-loop mechanical system that uses compressed air or hydraulic fluid to operate lifts, elevators, and other similar devices.

"Institutional controls" means the restriction on use or access (for example, fences, deed restrictions, restrictive zoning) to a site or facility to eliminate or minimize potential exposure to a chemical(s) of concern. Institutional controls include any of the following:

1. A law of the United States or the state;
2. A regulation issued pursuant to federal or state laws;
3. An ordinance or regulation of a political subdivision in which real estate subject to the institutional control is located;
4. A restriction on the use of or activities occurring at real estate which are embodied in a covenant running with the land which:

- Contains a legal description of the real estate in a manner which satisfies Iowa Code section 558.1 et seq.;
- Is properly executed, in a manner which satisfies Iowa Code section 558.1 et seq.;
- Is recorded in the appropriate office of the county in which the real estate is located;
- Adequately and accurately describes the institutional control; and
- Is in the form of a covenant as set out in Appendix C or in such a manner reasonably acceptable to the department.

5. Any other institutional control the owner or operator can reasonably demonstrate to the department which will reduce the risk from a release throughout the period necessary to ensure that no applicable target risk is likely to be exceeded.

"Liquid trap" means sumps, well cellars, and other traps used in association with oil and gas production, gathering, and extraction operations (including gas production plants), for the purpose of collecting oil, water, and other liquids. These liquid traps may temporarily collect liquids for subsequent disposition or reinjection into a production or pipeline stream, or may collect and separate liquids from a gas stream.

"Maintenance" means the normal operational upkeep to prevent an underground storage tank system from releasing product.

"MCLs" means the drinking water primary maximum contaminant levels set out in 567—41.3(455B).

"Memorandum of agreement" means a written agreement between the department and the owner or operator which specifies the corrective action that will be undertaken by the owner or operator in order to comply with requirements in this chapter and the terms for implementation of the plan. The plan may include but is not limited to provisions for additional site assessment, site monitoring, Tier 2 revisions, Tier 3 assessment, excavation, and other soil and groundwater remedial action.

"Motor fuel" means petroleum or a petroleum-based substance that is motor gasoline, aviation gasoline, No. 1 or No. 2 diesel fuel, or any grade of gasohol, and is typically used in the operation of a motor engine.

"New tank system" means a tank system that will be used to contain an accumulation of regulated substances and for which installation has commenced after January 14, 1987. (See also "Existing Tank System.")

"Noncarcinogenic risk" means the potential for adverse systemic or toxic effects caused by exposure to noncarcinogenic chemicals of concern, expressed as the hazard quotient.

"Noncommercial purposes" with respect to motor fuel means not for resale.

"Non-drinking water well" means any groundwater well (except an extraction well used as part of a remediation system) not defined as a drinking water well including a groundwater well which is not properly plugged in accordance with department rules in 567—Chapters 39 and 49.

"Nonresidential area" means land which is not currently used as a residential area and which is zoned for nonresidential uses.

"On the premises where stored" with respect to heating oil means UST systems located on the same property where the stored heating oil is used.

"Operational life" refers to the period beginning when installation of the tank system has commenced until the time the tank system is properly closed under rule 135.15(455B).

"Operator" means any person in control of, or having responsibility for, the daily operation of the UST system.

"Overfill release" is a release that occurs when a tank is filled beyond its capacity, resulting in a discharge of the regulated substance to the environment.

"Owner" means:

1. In the case of a UST system in use on July 1, 1985, or brought into use after that date, any person who owns a UST system used for storage, use, or dispensing of regulated substances; and

2. In the case of any UST system in use before July 1, 1985, but no longer in use on that date, any person who owned such UST immediately before the discontinuation of its use.

"Owner" does not include a person, who, without participating in the management or operation of the underground storage tank or the tank site, holds indicia of ownership primarily to protect that person's security interest in the underground storage tank or the tank site property, prior to obtaining ownership or control through debt enforcement, debt settlement, or otherwise.

"Pathway" means a transport mechanism by which chemicals of concern may reach a receptor(s) or the location(s) of a potential receptor.

"Permanent closure" means removing all regulated substances from the tank system, assessing the site for contamination, and permanently removing tank and piping from the ground or filling the tank in place with a solid inert material and plugging all piping. Permanent closure also includes partial closure of a tank system such as removal or replacement of tanks or piping only.

"Person" means an individual, trust, firm, joint stock company, federal agency, corporation, state, municipality, commission, political subdivision of a state, or any interstate body. "Person" also includes a consortium, a joint venture, a commercial entity, and the United States government.

"Person who conveys or deposits a regulated substance" means a person who sells or supplies the owner or operator with the regulated substance and the person who transports or actually deposits the regulated substance in the underground tank.

"Petroleum UST system" means an underground storage tank system that contains petroleum or a mixture of petroleum with de minimus quantities of other regulated substances. Such systems include those containing motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

"Pipe" or *"piping"* means a hollow cylinder or tubular conduit that is constructed of nonearthen materials and that routinely contains and conveys regulated substances from the underground tank(s) to the dispenser(s) or other end-use equipment. Such piping includes any elbows, couplings, unions, valves, or other in-line fixtures that contain and convey regulated substances from the underground tank(s) to the dispenser(s). This definition does not include vent, vapor recovery, or fill lines.

"Pipeline facilities (including gathering lines)" are new and existing pipe rights-of-way and any associated equipment, facilities, or buildings.

"Point of compliance" means the location(s) at the source(s) of contamination or at the location(s) between the source(s) and the point(s) of exposure where concentrations of chemicals of concern must meet applicable risk-based screening levels at Tier 1 or other target level(s) at Tier 2 or Tier 3.

"Point of exposure" means the location(s) at which an actual or potential receptor may be exposed to chemicals of concern via a pathway.

"Potential receptor" means a receptor not in existence at the time a Tier 1, Tier 2 or Tier 3 site assessment is prepared, but which could reasonably be expected to exist within 20 years of the preparation of the Tier 1, Tier 2 or Tier 3 site assessment or as otherwise specified in these rules.

"Preferential pathway" means conditions which act as a pathway permitting contamination to migrate through soils and to groundwater at a faster rate than would be expected through naturally occurring undisturbed soils or unfractured bedrock including but not limited to wells, cisterns, tile lines, drainage systems, utility lines and envelopes, and conduits.

"Protected groundwater source" means a saturated bed, formation, or group of formations which has a hydraulic conductivity of at least 0.44 meters per day (m/d) and a total dissolved solids of less than 2,500 milligrams per liter (mg/l) or a bedrock aquifer with total dissolved solids of less than 2,500 milligrams per liter (mg/l) if bedrock is encountered before groundwater.

"Public water supply well" means a well connected to a system for the provision to the public of piped water for human consumption, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

"Receptor" means enclosed spaces, conduits, protected groundwater sources, drinking and non-drinking water wells, surface water bodies, and public water systems which when impacted by chemicals of concern may result in exposure to humans and aquatic life, explosive conditions or other adverse effects on health, safety and the environment as specified in these rules.

"Reference dose" means a designated toxicity value established in these rules for evaluating potential noncarcinogenic effects in humans resulting from exposure to a chemical(s) of concern. Reference doses are designated in Appendix A.

"Regulated substance" means an element, compound, mixture, solution or substance which, when released into the environment, may present substantial danger to the public health or welfare or the environment. Regulated substance includes:

1. Substances designated in Table 302.4 of 40 CFR Part 302 (September 13, 1988),
2. Substances which exhibit the characteristics identified in 40 CFR 261.20 through 261.24 (May 10, 1984) and which are not excluded from regulation as a hazardous waste under 40 CFR 261.4(b) (May 10, 1984),
3. Any substance defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) of 1980 (but not including any substance regulated as a hazardous waste under subtitle C), and
4. Petroleum, including crude oil or any fraction thereof that is liquid at standard conditions of temperature and pressure (60 degrees Fahrenheit and 14.7 pounds per square inch absolute). The term "regulated substance" includes but is not limited to petroleum and petroleum-based substances comprised of a complex blend of hydrocarbons derived from crude oil through processes of separation, conversion, upgrading, and finishing, such as motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

"Release" means any spilling, leaking, emitting, discharging, escaping, leaching or disposing of a regulated substance, including petroleum, from a UST into groundwater, surface water or subsurface soils.

"Release detection" means determining whether a release of a regulated substance has occurred from the UST system into the environment or into the interstitial space between the UST system and its secondary barrier or secondary containment around it.

"Repair" means to restore a tank or UST system component that has caused a release of product from the UST system.

"Replace" or *"replacement"* means the installation of a new underground tank system or component, including dispensers, in substantially the same location as an existing tank system or component in lieu of that tank system or component.

"Residential area" means land used as a permanent residence or domicile, such as a house, apartment, nursing home, school, child care facility or prison, land zoned for such uses, or land where no zoning is in place.

"Residential tank" is a tank located on property used primarily for dwelling purposes.

"Risk-based screening level (RBSL)" means the risk-based concentration level for chemicals of concern developed for a Tier 1 analysis to be met at the point(s) of compliance and incorporated in the Tier 1 Look-up Table in Appendix A.

"SARA" means the federal Superfund Amendments and Reauthorization Act of 1986.

"Secondary containment tank" or *"secondary containment piping"* means a tank or piping which is designed with an inner primary shell and a liquid-tight outer secondary shell or jacket which extends around the entire inner shell, and which is designed to contain any leak through the primary shell from any part of the tank or piping that routinely contains product, and which also allows for monitoring of the interstitial space between the shells and the detection of any leak.

"Sensitive area" means a screening tool used to determine if a public water supply well warrants a more in-depth assessment. It is not intended to be a mechanism to assign a risk classification to the public water supply well receptor. "Sensitive area" describes the area within the Iowa Geological Survey's designated five-year capture zone for any public water supply well or, if the Iowa Geological Survey has not designated a five-year capture zone for a public water supply well, the area within a 2,500-foot radius of the public water supply well and where the Iowa Geological Survey has given the public water supply well aquifer a source water protection aquifer designation of "susceptible" or "highly susceptible."

"Septic tank" is a watertight covered receptacle designed to receive or process, through liquid separation or biological digestion, the sewage discharged from a building sewer. The effluent from such receptacle is distributed for disposal through the soil and settled solids and scum from the tank are pumped out periodically and hauled to a treatment facility.

"Site assessment investigation" means an investigation conducted by a registered groundwater professional to determine relevant site historical data, the types, amounts, and sources of petroleum contaminants present, hydrogeological characteristics of the site, full vertical and horizontal extent of the contamination in soils and groundwater, direction and rate of flow of the contamination, ranges of concentration of the contaminants by analysis of soils and groundwater, the vertical and horizontal extent of the contamination exceeding department standards, and the actual or potential threat to public health and safety and the environment.

"Site cleanup report" means the report required to be submitted by these rules and in accordance with department guidance which may include the results of Tier 2 or Tier 3 assessment and analysis.

"Site-specific target level (SSTL)" means the risk-based target level(s) for chemicals of concern developed as the result of a Tier 2 or Tier 3 assessment which must be achieved at applicable point(s) of compliance at the source to meet the target level(s) at the point(s) of exposure.

"Soil leaching to groundwater pathway" means a pathway through soil by which chemicals of concern may leach to groundwater and through a groundwater transport pathway impact an actual or potential receptor.

"Soil plume" means the vertical and horizontal extent of soil impacted by the release of chemicals of concern.

"Soil to plastic water line pathway" means a pathway which leads from soil to a plastic water line.

"Soil vapor to enclosed space pathway" means a pathway through soil by which vapors from chemicals of concern may lead to a receptor creating an inhalation or explosive risk hazard.

"Storm water or wastewater collection system" means piping, pumps, conduits, and any other equipment necessary to collect and transport the flow of surface water run-off resulting from precipitation, or domestic, commercial, or industrial wastewater to and from retention areas or any areas where treatment is designated to occur. The collection of storm water and wastewater does not include treatment except where incidental to conveyance.

"Surface impoundment" is a natural topographic depression, constructed excavation, or diked area formed primarily of earthen materials (although it may be lined with manufactured materials) that is not an injection well.

"Surface water body" means general use segments as provided in 567—paragraph 61.3(1)*"a"* and designated use segments of water bodies as provided in 567—paragraph 61.3(1)*"b"* and 567—subrule 61.3(5).

"Surface water criteria" means, for chemicals of concern, the Criteria for Chemical Constituents in Table 1 of rule 567—61.3(455B), except that "1,000 ug/L" will be substituted for the chronic levels for toluene for Class B designated use segments.

"Surface water pathway" means a pathway which leads to a surface water body.

"Tank" is a stationary device designed to contain an accumulation of regulated substances and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

"Target level" means the allowable concentrations of chemicals of concern established to achieve an applicable target risk which must be met at the point(s) of compliance as specified in these rules.

"Target risk" refers to an applicable carcinogenic and noncarcinogenic risk factor designated in these rules and used in determining target levels (for carcinogenic risk assessment, target risk is a separate factor, different from exposure factors, both of which are used in determining target levels).

"Technological controls" means a physical action which does not involve source removal or reduction, but severs or reduces exposure to a receptor, such as caps, containment, carbon filters, point of use water treatment, etc.

"Tier 1 level" means the groundwater and soil levels in the Tier 1 Look-up Table set out in rule 135.9(455B) and Appendix A.

"Tier 1 site assessment" means the evaluation of limited site-specific data compared to the Tier 1 levels established in these rules for the purpose of determining which pathways do not require assessment and evaluation at Tier 2 and which sites warrant a no further action required classification without further assessment and evaluation.

"Tier 2 site assessment" means the process of assessing risk to actual and potential receptors by using site-specific field data and designated Tier 2 exposure and fate and transport models to determine the applicable target level(s).

"Tier 3 site assessment" means a site-specific risk assessment utilizing more sophisticated data or analytic techniques than a Tier 2 site assessment.

"Under-dispenser containment (UDC)" means containment underneath a dispenser that will prevent leaks from the dispenser from reaching soil or groundwater. Such containment must:

- Be intact and liquid-tight on its sides and bottom and at any penetrations;
- Be compatible with the substance conveyed by the piping; and
- Allow for visual inspection and monitoring and access to the components in the containment system.

"Underground area" means an underground room, such as a basement, cellar, shaft or vault, providing enough space for physical inspection of the exterior of the tank situated on or above the surface of the floor.

"Underground release" means any below-ground release.

"Underground storage tank" or *"UST"* means any one or combination of tanks (including underground pipes connected thereto) that is used to contain an accumulation of regulated substances, and the volume of which (including the volume of underground pipes connected thereto) is 10 percent or more beneath the surface of the ground. This term does not include any:

a. Farm or residential tank of 1100 gallons or less capacity used for storing motor fuel for noncommercial purposes. Iowa Code section 455B.471 requires those tanks existing prior to July 1, 1987, to be registered. Tanks installed on or after July 1, 1987, must comply with all 567—Chapter 135 rules;

b. Tank used for storing heating oil for consumptive use on the premises where stored;

c. Septic tank;

d. Pipeline facility (including gathering lines) regulated under:

(1) The Natural Gas Pipeline Safety Act of 1968 (49 U.S.C. App. 1671, et seq.), or

(2) The Hazardous Liquid Pipeline Safety Act of 1979 (49 U.S.C. App. 2001, et seq.), or

(3) Which is an intrastate pipeline facility regulated under state laws comparable to the provisions of the law referred to in *"d"*(1) or *"d"*(2) of this definition;

e. Surface impoundment, pit, pond, or lagoon;

f. Storm-water or wastewater collection system;

g. Flow-through process tank;

h. Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations; or

i. Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor.

The term "underground storage tank" or "UST" does not include any pipes connected to any tank which is described in paragraphs *"a"* through *"j"* of this definition.

"Underground utility vault" means any constructed space accessible for inspection and maintenance associated with subsurface utilities.

"Unreasonable risk to public health and safety or the environment" means the Tier 1 levels for a Tier 1 site assessment, the applicable target level for a Tier 2 site assessment, and the applicable target level for a Tier 3 site assessment.

"Upgrade" means the addition or retrofit of some systems such as cathodic protection, lining, or spill and overfill controls to improve the ability of an underground storage tank system to prevent the release of product.

"UST system" or *"tank system"* means an underground storage tank, connected underground piping, underground ancillary equipment, and containment system, if any.

"Utility envelope" means the backfill and trench used for any subsurface utility line, drainage system and tile line.

"Wastewater treatment tank" means a tank that is designed to receive and treat an influent wastewater through physical, chemical, or biological methods.

567—135.3(455B) UST systems—design, construction, installation and notification.

135.3(1) *Performance standards for new UST systems.* In order to prevent releases due to structural failure, corrosion, or spills and overfills for as long as the UST system is used to store regulated substances, all owners and operators of new UST systems must meet the following requirements.

a. Tanks. Each tank must be properly designed and constructed, and any portion underground that routinely contains product must be protected from corrosion, in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory as specified below:

(1) The tank is constructed of fiberglass-reinforced plastic; or

NOTE: The following industry codes may be used to comply with 135.3(1)*"a"*(1): Underwriters Laboratories Standard 1316, "Standard for Glass-Fiber-Reinforced Plastic Underground Storage Tanks for Petroleum Products"; Underwriters Laboratories of Canada CAN4-S615-M83, "Standard for Reinforced Plastic Underground Tanks for Petroleum Products"; or American Society of Testing and Materials Standard D4021-86, "Standard Specification for Glass-Fiber-Reinforced Polyester Underground Petroleum Storage Tanks."

(2) The tank is constructed of steel and cathodically protected in the following manner:

1. The tank is coated with a suitable dielectric material;
2. Field-installed cathodic protection systems are designed by a corrosion expert;

3. Impressed current systems are designed to allow determination of current operating status as required in 135.4(2)*"c"*; and

4. Cathodic protection systems are operated and maintained in accordance with 135.4(2) or according to guidelines established by the department; or

NOTE: The following codes and standards may be used to comply with 135.3(1)*"a"*(2): Steel Tank Institute "Specification for STI-P3 System of External Corrosion Protection of Underground Steel Storage Tanks"; Underwriters Laboratories Standard 1746, "Corrosion Protection Systems for Underground Storage Tanks"; Underwriters Laboratories of Canada CAN4-S603-M85, "Standard for Steel Underground Tanks for Flammable and Combustible Liquids," and CAN4-GO3.1-M85, "Standard for Galvanic Corrosion Protection Systems for Underground Tanks for Flammable and Combustible Liquids," and CAN4-S631-M84, "Isolating Bushings for Steel Underground Tanks Protected with Coatings and Galvanic Systems"; or National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," and Underwriters Laboratories Standard 58, "Standard for Steel Underground Tanks for Flammable and Combustible Liquids."

(3) The tank is constructed of a steel-fiberglass-reinforced plastic composite; or

NOTE: The following industry codes may be used to comply with 135.3(1)*"a"*(3): Underwriters Laboratories Standard 1746, "Corrosion Protection Systems for Underground Storage Tanks," or the Association for Composite Tanks ACT-100, "Specification for the Fabrication of FRP Clad Underground Storage Tanks."

(4) The tank is constructed of metal without additional corrosion protection measures provided that:

1. The tank is installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operating life; and

2. Owners and operators maintain records that demonstrate compliance with the requirements of 135.3(1)*"a"*(4)"1" for the remaining life of the tank; or

(5) The tank construction and corrosion protection are determined by the department to be designed to prevent the release or threatened release of any stored regulated substance in a manner that is no less protective of human health and the environment than 135.3(1)*"a"* (1) to (4).

b. Piping. The piping that routinely contains regulated substances and is in contact with the ground must be properly designed, constructed, and protected from corrosion in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory as specified below:

(1) The piping is constructed of fiberglass-reinforced plastic; or

NOTE: The following codes and standards may be used to comply with 135.3(1)*"b"*(1): Underwriters Laboratories Subject 971, "UL Listed Non-Metal Pipe"; Underwriters Laboratories Standard 567, "Pipe Connectors for Flammable and Combustible and LP Gas"; Underwriters Laboratories of Canada Guide ULC-107, "Glass Fiber Reinforced Plastic Pipe and Fittings for Flammable Liquids"; and Underwriters Laboratories of Canada Standard CAN 4-S633-M81, "Flexible Underground Hose Connectors."

(2) The piping is constructed of steel and cathodically protected in the following manner:

1. The piping is coated with a suitable dielectric material;

2. Field-installed cathodic protection systems are designed by a corrosion expert;

3. Impressed current systems are designed to allow determination of current operating status as required in 135.4(2)*"c"*; and

4. Cathodic protection systems are operated and maintained in accordance with 135.4(2) or guidelines established by the department; or

NOTE: The following codes and standards may be used to comply with 135.3(1)*"b"*(2): National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; American Petroleum Institute Publication 1615, "Installation of Underground Petroleum Storage Systems"; American Petroleum Institute Publication 1632, "Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems"; and National Association of Corrosion Engineers Standard RP-01-69, "Control of External Corrosion on Submerged Metallic Piping Systems."

(3) The piping is constructed of metal without additional corrosion protection measures provided that:

1. The piping is installed at a site that is determined by a corrosion expert to not be corrosive enough to cause it to have a release due to corrosion during its operating life; and

2. Owners and operators maintain records that demonstrate compliance with the requirements of 135.3(1)*"b"*(3)"1" for the remaining life of the piping; or

NOTE: National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; and National Association of Corrosion Engineers Standard RP-01-69, "Control of External Corrosion on Submerged Metallic Piping Systems," may be used to comply with 135.3(1)*"b"*(3).

(4) The piping construction and corrosion protection are determined by the department to be designed to prevent the release or threatened release of any stored regulated substance in a manner that is no less protective of human health and the environment than the requirements in 135.3(1)*"b"*(1) to (3).

c. Spill and overfill prevention equipment.

(1) Except as provided in subparagraph (2), to prevent spilling and overfilling associated with product transfer to the UST system, owners and operators must use the following spill and overfill prevention equipment:

1. Spill prevention equipment that will prevent release of product to the environment when the transfer hose is detached from the fill pipe (for example, a spill catchment basin); and

2. Overfill prevention equipment that will:

Automatically shut off flow into the tank when the tank is no more than 95 percent full; or

Alert the transfer operator when the tank is no more than 90 percent full by restricting the flow into the tank or triggering a high-level alarm; or

Restrict flow 30 minutes prior to overfilling, alert the operator with a high-level alarm one minute before overfilling, or automatically shut off the flow into the tank so that none of the fittings located on top of the tank are exposed to product due to overfilling.

(2) Owners and operators are not required to use the spill and overfill prevention equipment specified in subparagraph (1) if:

1. Alternative equipment is used that is determined by the department to be no less protective of human health and the environment than the equipment specified in subparagraph (1)"1" or "2" of this paragraph; or

2. The UST system is filled by transfers of no more than 25 gallons at one time.

d. Installation. All tanks and piping must be properly installed in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory and in accordance with the manufacturer's instructions.

NOTE: Tank and piping system installation practices and procedures described in the following codes may be used to comply with the requirements of 135.3(1)*"d"*: American Petroleum Institute Publication 1615, "Installation of Underground Petroleum Storage System"; Petroleum Equipment Institute Publication RP100, "Recommended Practices for Installation of Underground Liquid Storage Systems"; or American National Standards Institute Standard 831.3, "Petroleum Refinery Piping," and American National Standards Institute Standard 831.4, "Liquid Petroleum Transportation Piping System."

e. Certification of installation. All owners and operators must ensure that one or more of the following methods of certification, testing, or inspection is used to demonstrate compliance with paragraph *"d"* of this subrule by providing a certification of compliance on the UST notification form in accordance with 135.3(3).

(1) The installer has been certified by the tank and piping manufacturers; or

(2) The installer has been certified or licensed by the department as provided in 567—Chapter 134, Part C; or

(3) The installation has been inspected and certified by a registered professional engineer with education and experience in UST system installation; or

(4) The installation has been inspected and approved by an inspector certified or licensed by the Iowa comprehensive petroleum underground storage tank fund board; or

(5) All work listed in the manufacturer's installation checklists has been completed; or

(6) The owner and operator have complied with another method for ensuring compliance with paragraph *"d"* that is determined by the department to be no less protective of human health and the environment.

135.3(2) *Upgrading of existing UST systems.*

a. Alternatives allowed. Not later than December 22, 1998, all existing UST systems must comply with one of the following requirements:

(1) New UST system performance standards under 135.3(1);

(2) The upgrading requirements in paragraphs *"b"* through *"d"* below; or

(3) Closure requirements under rule 135.15(455B), including applicable requirements for corrective action under rules 135.7(455B) to 135.12(455B).

Replacement or upgrade of a tank system on a petroleum contaminated site classified as a high or low risk in accordance with subrule 135.12(455B) shall be a double wall tank or a tank equipped with a secondary containment

system with monitoring of the space between the primary and secondary containment structures in accordance with 135.5(4)*"g"* or other approved tank system or methodology approved by the Iowa comprehensive petroleum underground storage tank fund board.

b. Tank upgrading requirements. Steel tanks must be upgraded to meet one of the following requirements in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory:

(1) *Interior lining.* A tank may be upgraded by internal lining if:

1. The lining is installed in accordance with the requirements of 135.4(4), and

2. Within ten years after lining, and every five years thereafter, the lined tank is internally inspected and found to be structurally sound with the lining still performing in accordance with original design specifications.

(2) *Cathodic protection.* A tank may be upgraded by cathodic protection if the cathodic protection system meets the requirements of 135.3(1)*"a"*(2)"2," "3," and "4" and the integrity of the tank is ensured using one of the following methods:

1. The tank is internally inspected and assessed to ensure that the tank is structurally sound and free of corrosion holes prior to installing the cathodic protection system; or

2. The tank has been installed for less than ten years and is monitored monthly for releases in accordance with 135.5(4)*"d"* through *"h"*; or

3. The tank has been installed for less than ten years and is assessed for corrosion holes by conducting two tightness tests that meet the requirements of 135.5(4)*"c."* The first tightness test must be conducted prior to installing the cathodic protection system. The second tightness test must be conducted between three and six months following the first operation of the cathodic protection system; or

4. The tank is assessed for corrosion holes by a method that is determined by the department to prevent releases in a manner that is no less protective of human health and the environment than 135.3(2)*"b"*(2)"1" to "3."

(3) *Internal lining combined with cathodic protection.* A tank may be upgraded by both internal lining and cathodic protection if:

1. The lining is installed in accordance with the requirements of 135.4(4); and

2. The cathodic protection system meets the requirements of 135.3(1)*"a"*(2)"2," "3," and "4."

NOTE: The following codes and standards may be used to comply with subrule 135.3(2): American Petroleum Institute Publication 1631, "Recommended Practice for the Interior Lining of Existing Steel Underground Storage Tanks"; National Leak Prevention Association Standard 631, "Spill Prevention, Minimum 10-Year Life Extension of Existing Steel Underground Tanks by Lining Without the Addition of Cathodic Protection"; National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems"; and American Petroleum Institute Publication 1632, "Cathodic Protection of Underground Petroleum Storage Tanks and Piping Systems."

c. Piping upgrading requirements. Metal piping that routinely contains regulated substances and is in contact with the ground must be cathodically protected in accordance with a code of practice developed by a nationally recognized association or independent testing laboratory and must meet the requirements of 135.3(1)*"b"*(2)"2," "3," and "4."

NOTE: The codes and standards listed in the note following 135.3(1)*"b"*(2) may be used to comply with this requirement.

d. Spill and overfill prevention equipment. To prevent spilling and overfilling associated with product transfer to the UST system, all existing UST systems must comply with new UST system spill and overfill prevention equipment requirements specified in 135.3(1)*"c."*

135.3(3) *Notification requirements.*

a. Except as provided in 135.3(3)*"b,"* the owner of an underground storage tank existing on or before July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department by May 1, 1986.

b. The owner of an underground storage tank taken out of operation between January 1, 1974, and July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department by May 8, 1986, unless the owner knows the tank has been removed from the ground. For purposes of this subrule, "owner" means the person who owned the tank immediately before the discontinuation of the tank's use.

c. An owner or operator who brings into use an underground storage tank after July 1, 1985, shall complete and submit to the department a copy of the notification form provided by the department within 30 days of installing the tank in the ground. The owner or operator shall not allow the deposit of any regulated substance into the tank

without prior approval of the department or until the tank has been issued a tank registration tag and is covered by an approved financial responsibility mechanism in accordance with 567—Chapter 136.

d. All owners and operators of new UST systems must certify in the notification form compliance with the following requirements:

(1) Installation of tanks and piping under 135.3(1)*"e"*;

(2) Cathodic protection of steel tanks and piping under 135.3(1)*"a"* and *"b"*;

(3) Financial responsibility under 567—Chapter 136, Iowa Administrative Code;

(4) Release detection under 135.5(2) and 135.5(3).

e. All owners and operators of new UST systems must ensure that the installer certifies in the notification form that the methods used to install the tanks and piping comply with the requirements in 135.3(1)*"d."*

f. Exemption from reporting requirement. Paragraphs *"a"* to *"c"* do not apply to an underground storage tank for which notice was given pursuant to Section 103, Subsection c, of the Comprehensive Environmental Response, Compensation and Liabilities Act of 1980. (42 U.S.C. Subsection 9603(c))

g. Reporting fee. The notice by the owner to the department under paragraphs *"a"* to *"c"* shall be accompanied by a fee of $10 for each tank included in the notice.

h. Notification requirement for installing a tank. A person installing an underground storage tank and the owner or operator of the underground storage tank must notify the department of their intent to install the tank 30 days prior to installation. Notification shall be on a form provided by the department.

i. Notification requirements for a person who sells, installs, modifies or repairs a tank. A person who sells, installs, modifies, or repairs a tank used or intended to be used in Iowa shall notify, in writing, the purchaser and the owner or operator of the tank of the obligations specified in paragraphs 135.3(3)*"c"* and *"j"* and the financial assurance requirements in 567—Chapter 136. The notification must include the prohibition on depositing a regulated substance into tanks which have not been registered and issued tags by the department. A standard notification form supplied by the department may be used to satisfy this requirement.

j. It is unlawful for a person to deposit or accept a regulated substance in an underground storage tank that has not been registered and issued permanent or annual tank management tags in accordance with rule 567—135.3(455B). It is unlawful for a person to deposit or accept a regulated substance into an underground storage tank if the person has received notice from the department that the underground storage tank is subject to a delivery prohibition or if there is a "red tag" attached to the UST fill pipe or fill pipe cap as provided in subrule 135.3(8).

(1) The department may provide written authorization to receive a regulated substance when there is a delay in receiving tank tags or at new tank installations to allow for testing the tank system.

(2) The department may provide known depositors of regulated substances lists of underground storage tank sites that have been issued tank tags, those that have not been issued tank tags, and those subject to a delivery prohibition pursuant to subrule 135.3(8). These lists do not remove the requirement for depositors to verify that current tank tags are affixed to the fill pipe prior to delivering product. Regulated substances cannot be delivered to underground storage tanks without current tank tags or those displaying a delivery prohibition "red tag" as provided in subrule 135.3(8).

(3) A person shall not deposit a regulated substance in an underground storage tank after receiving written or oral notice from the department that the tank is not covered by an approved form of financial responsibility in accordance with 567—Chapter 136.

k. If an owner or operator fails to register an underground storage tank within 30 days after installation or obtain annual renewal tags by April 1, the owner or operator shall pay an additional $250 upon registration of the tank or application for tank tag renewal. The imposition of this fee does not preclude the department from assessing an additional administrative penalty in accordance with Iowa Code section 455B.476.

135.3(4) *Farm and residential tanks.*

a. The owner or operator of a farm or residential tank of 1100 gallons or less capacity used for storing motor fuel for noncommercial purposes is subject to the requirements of this subrule.

b. Farm and residential tanks, installed before July 1, 1987, shall be reported on a notification form by July 1, 1989, but owners or operators are not required to pay a registration fee.

c. Farm and residential tanks that were installed on or after July 1, 1987, shall be in compliance with all the underground storage tank regulations.

135.3(5) *Registration tags and annual management fee.*

a. Tanks of 1100 gallons or less capacity that have registered with the department will be issued a permanent registration tag.

b. The owner or operator of tanks over 1100-gallon capacity must submit a tank management fee of $65 per tank by January 15 of each year. The owner or operator must also submit written proof that the tanks are covered by an approved form of financial responsibility in accordance with 567—Chapter 136. Upon proper payment of the fee and acceptable proof of financial responsibility, a one-year registration tag will then be issued for the period from April 1 to March 31. The department shall refund a tank management fee if the tank is permanently closed prior to the effective date of April 1 for that year.

c. The owner or operator shall affix the tag to the fill pipe of the underground storage tank where it will be readily visible.

d. A person who conveys or deposits a regulated substance shall inspect the underground storage tank to determine the existence or absence of a current registration tag, a current annual tank management fee tag, or a delivery prohibition "red tag" as provided in subrule 135.3(8). If the tag is not affixed to the fill pipe or fill pipe cap or if a delivery prohibition "red tag" is displayed, the person shall not deposit the substance in the tank.

e. The owner or operator must return the tank tags upon request of the department for failure to meet the requirements of rules 135.3(455B) to 135.5(455B) or the financial responsibility rules in 567—Chapter 136 after permanent tank closure or when tanks are temporarily closed for over 12 months, or when the tank system is suspected to be leaking and the responsible party fails to respond as required in subrule 135.8(1). The department will not return the tags until the tank system is in full compliance with the technical requirements of this chapter and financial responsibility requirements of 567—Chapter 136.

135.3(6) *Petroleum underground storage tank registration amnesty program.*

a. A petroleum underground storage tank required to be registered under 135.3(3) and 135.3(4), which has not been registered prior to July 1, 1988, may be registered under the following conditions:

(1) The tank registration fee under 135.3(3)*"g"* shall accompany the registration.

(2) The storage tank management fee under 135.3(5) shall be paid for past years in which the tank should have been registered.

b. If a tank is registered under this subrule on or prior to October 1, 1989, penalties under Iowa Code section 455B.477 shall be waived.

135.3(7) *Exemption certificates from the environmental charge on petroleum diminution.*

a. An owner or operator of a petroleum underground storage tank that is exempt, deferred, or excluded from regulation under Iowa Code sections 455G.1 to 455G.17, can apply for an exemption certificate from the department to exempt a tank from the environmental charge on petroleum diminution. Exempted tanks include those listed in 135.1(3)*"b"* and *"c"* and those excluded in the definition of "underground storage tank" in 135.2(455B). Application for the exemption certificate shall be made on the form provided by the department.

b. An exemption certificate is not required for those classes of tanks that the Iowa comprehensive petroleum underground storage tank fund board has waived from the exemption certificate requirement.

c. The department shall revoke and require the return of the exemption certificate if the petroleum underground storage tank becomes subject to Iowa Code sections 455G.1 to 455G.17.

135.3(8) *Delivery prohibition process.*

a. Identifying sites subject to delivery response prohibition action.

(1) Annual registration tag and tank management fee process. Owners and operators shall certify to the following on a form prepared by the department when applying for annual tank tags pursuant to subrule 135.3(5):

1. Installation and performance of an approved UST and piping release detection method as provided in rule 135.5(455B), including an annual line tightness test and a line leak detector test if applicable.

2. Installation of an approved overfill and spill protection system as provided in paragraph 135.3(1)*"c."*

3. Installation of an approved corrosion protection system as provided in paragraphs 135.3(1)*"a"* and *"b."*

4. If the UST system has been out of operation for more than three months, that the UST system has been temporarily closed in accordance with rule 135.15(455B) and a certification of temporary closure has been submitted to the department.

5. If the UST system has been removed or filled in place within the last 12 months, the date of removal or filling in place and whether a closure report has been submitted as provided in rule 135.15(455B).

(2) Sites with provisional status. If the UST system has been classified as operating under provisional status as provided in paragraph 135.3(8)*"c,"* owners and operators when applying for annual tank tags pursuant to subrule

135.3(5) must certify on a form prepared by the department that the owners and operators are in compliance with an approved provisional status remedial plan as provided in paragraph 135.3(8)*"c."*

(3) Compliance inspections. The department may initiate a delivery prohibition response action based on: (1) a finding resulting from a third-party compliance inspection conducted pursuant to rule 135.20(455B); (2) a department investigation and inspection conducted pursuant to Iowa Code section 455B.475; or (3) review of a UST system check or other documentation submitted in response to a suspected release under rule 135.6(455B) or in response to a confirmed release under rule 135.7(455B).

b. Delivery prohibition eligibility criteria. A delivery prohibition response action may be initiated upon a finding that the UST system is out of compliance with department rules and meets the eligibility criteria as specified below. Reinstatement criteria define the standards and process for owners and operators to document that they have taken corrective action sufficient to authorize resumption of fuel to the USTs. Prior to initiation of the delivery prohibition, owners and operators are afforded a minimum level of procedural due process such as prior notice and the opportunity to present facts to dispute the finding. Where notice and the opportunity to take corrective action prior to initiation of a delivery prohibition response action are required, notice by the department or by a certified compliance inspector as provided in rule 135.20(455B) shall be sufficient.

If the department finds that any one of the following criteria has been satisfied, the department may initiate a delivery prohibition response action following the notice procedures outlined in paragraph *"e"* of this subrule. After initiation of the delivery prohibition response action, the department will offer the owner or operator an opportunity to establish reinstatement criteria by written documentation and, if requested, an in-person meeting.

(1) An approved release detection method for USTs or UST piping is not installed, such as automatic tank gauging, groundwater monitoring wells and line leak detectors, and there is no record that an approved method such as inventory control, statistical inventory reconciliation, or interstitial space monitoring has been employed during the previous three months. If the owner or operator claims to have documentation that an approved release detection method has been conducted, the owner or operator will be given two business days to produce the documentation.

REINSTATEMENT CRITERIA: The owner or operator must submit results of a passing UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b."* The owner or operator must also document installation and operation of an approved release detection system. This may include proof that a contract has been signed with a qualified statistical inventory reconciliation provider or that a qualified inventory control method has been implemented and training has been provided to onsite supervisory personnel.

(2) No documentation of a required annual line tightness test or line leak detector test has been provided, and the owner or operator has failed to conduct the required testing within 14 days of written notice by the department or a certified compliance inspector as provided in rule 135.20(455B).

REINSTATEMENT CRITERIA: The owner or operator must provide documentation of a passing line precision tightness test at the 0.1 gallon-per-hour leak rate in paragraph 135.5(5)*"b"* and a line leak detector test as provided in paragraph 135.5(5)*"a."*

(3) Overfill and spill protection is not installed.

REINSTATEMENT CRITERION: The owner or operator must provide documentation that overfill and spill protection equipment has been installed.

(4) A corrosion protection system is not installed or there is no record that an impressed current corrosion protection system has been in operation for the prior six months.

REINSTATEMENT CRITERIA: A manned entry tank integrity inspection must be completed prior to installation of a corrosion protection system, and the owner or operator must submit results of a passing UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b."* A corrosion protection analysis must be completed and approved by the department.

(5) The owner or operator has failed to provide proof of financial responsibility in accordance with 567—Chapter 136.

REINSTATEMENT CRITERION: The owner or operator must submit acceptable proof of financial responsibility in accordance with 567—Chapter 136.

(6) A qualified UST system release detection method is installed and is being used but the documentation or the absence of documentation is sufficient to question the reliability of the release detection over the past 12-month period. The owner or operator shall be notified of the deficiencies, shall be given at least two business days to produce documentation of compliance and, if necessary, shall be required to conduct a leak detection system

analysis and a system tightness test within 14 days. If the owner or operator fails to produce documentation of compliance or to conduct the system analysis and the UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b,"* the department may initiate a delivery prohibition response action. Notice by the department or a compliance inspector as provided in rule 135.20(455B) shall be sufficient to initiate a delivery prohibition response action.

REINSTATEMENT CRITERIA: The owner or operator must submit documentation that the leak detection method analysis sufficiently documents compliance and explains the reasons for the accuracy and reliability concerns. If necessary, the owner or operator must submit passing results of a UST system precision tightness test at the 0.1 gallon-per-hour leak rate in paragraphs 135.5(4)*"c"* and 135.5(5)*"b."*

(7) The owner or operator has failed to document completion of a three-year corrosion protection test or to repair defective corrosion protection equipment within 30 days after notice of the violation by the department or a certified compliance inspector as provided in rule 135.20(455B).

REINSTATEMENT CRITERION: The owner or operator must submit documentation of a three-year corrosion protection test as provided in rule 135.3(455B).

(8) The owner or operator has failed to complete a compliance inspection required by rule 135.20(455B) within 60 days after written notice of the violation by the department.

REINSTATEMENT CRITERION: The owner or operator must submit a compliance inspection report as provided in rule 135.20(455B).

(9) The owner or operator has failed to take necessary abatement action in response to a confirmed release as provided in subrules 135.7(2) and 135.7(3).

REINSTATEMENT CRITERION: The owner or operator must document compliance with the abatement provisions in subrules 135.7(2) and 135.7(3).

(10) The owner or operator has failed to undertake and document release investigation and confirmation steps within seven days in response to a suspected release as provided in paragraph 135.6(3)*"a."*

REINSTATEMENT CRITERION: The owner or operator must document release confirmation and system check as provided in paragraph 135.6(3)*"a."*

c. Provisional status. The department may classify a UST system as operating under a provisional status when the department documents a pattern of UST operation and maintenance violations under rules 135.3(455B) through 135.5(455B) and suspected release and confirmed release response actions under rules 135.6(455B) and 135.7(455B). The department shall provide the owner or operator with a notice specifying the basis for the proposed classification and a proposed remedial action plan. The objective of the remedial action plan is to provide the owner and operator an opportunity to undertake certain remedial actions sufficient to establish a reasonable likelihood that future regulatory compliance will be achieved.

The remedial action plan may include but is not limited to provisions for owner/operator training, development of a facility-specific compliance manual, more frequent third-party compliance inspections than otherwise required under rule 135.20(455B), monthly reporting, and retention of a third-party compliance manager/consultant. If the owner or operator and the department cannot reach agreement on a remedial action plan, the department may initiate enforcement action by issuance of an administrative order pursuant to 567—Chapter 10. This provision does not grant the owner or operator an entitlement to this procedure, and the department reserves all discretion to undertake an enforcement action and assess penalties as provided in Iowa Code sections 455B.476 and 455B.477.

d. Administrative orders. The department may impose a delivery prohibition as a remedy for violations of the operation and maintenance provisions in rules 135.3(455B) through 135.5(455B) and the suspected and confirmed release response actions in rules 135.6(455B) and 135.7(455B). This remedy may be in addition to the assessment of penalties as provided in Iowa Code section 455B.476 and other appropriate injunctive relief necessary to correct violations.

e. Due process prior to initiation of a delivery prohibition response action.

(1) Prior to imposing a delivery prohibition response action under paragraph 135.3(8)*"b"* above, the department will provide notice to the owner or operator or, if notice to the owner or operator cannot be confirmed, to a person in charge at the UST facility of the basis for the finding and the intent to initiate a delivery prohibition response action. Notice may be by verbal contact, by facsimile, or by regular or certified mail to the UST facility address or the owner's or operator's last-known address. The owner and operator will be given a minimum of one business day to provide documentation that the finding is inaccurate or that reinstatement criteria in subparagraphs 135.3(8)*"b"*(1) through (5) have been satisfied. Additional days and the opportunity for a telephone or in-person

conference may be provided the owner and operator to contest the factual basis for a finding under subparagraphs 135.3(8)*"b"*(6) through (10). Additional procedural due process may be afforded the owner and operator on a case-by-case basis sufficient to satisfy Constitutional due process standards.

If insufficient information is submitted to change the finding, the department will notify the owner or operator and a person in charge at the UST facility of the final decision to impose the delivery prohibition response action.

(2) Provisional status. Upon a finding that an owner or operator under provisional status has failed to comply with the terms of a remedial action plan as provided above, the department may initiate a delivery prohibition response action by giving actual notice to the owner or operator of the basis for the finding of noncompliance and the department's intent to initiate a delivery prohibition response action. The delivery prohibition response action shall not be imposed without providing the owner or operator the opportunity for an evidentiary hearing consistent with the provisions for suspension and revocation of licenses under 567—Chapter 7.

f. Delivery prohibition procedure. Upon oral or written notice that the delivery prohibition response action has been imposed, the owner or operator and any person in charge of the UST facility shall be notified that they are not authorized to receive any further delivery of regulated substances until conditions for reinstatement of eligibility are satisfied. Owners and operators are required to immediately remove and return to the department the current annual tank management fee tags or the tank registration tags if there are no tank management fee tags. Owners and operators are required to provide the department with names and contact information for all persons who convey or deposit regulated substances to the USTs. The department will attempt to notify known persons who convey or deposit regulated substances to the USTs that they are not authorized to deliver to the USTs until further notice by the department as provided in paragraph 135.3(3)*"j"* and subrule 135.3(5).

If the tank tags are not returned within three business days, the department shall visit the site, remove the tags, and affix a "red tag" to the fill pipes or fill pipe caps of all affected USTs. It is unlawful for any person to deposit or accept a regulated substance into a UST that has a "red tag" affixed to the fill pipe or fill pipe cap. The department may allow the owner and operator to dispense and sell the remainder of existing fuel unless the department determines there is an immediate risk of a release or other risk to human health, safety or the environment. The department shall confirm in writing the basis for the delivery prohibition response action, contacts made prior to the action, and steps the owner or operator must take to reinstate fuel delivery.

135.3(9) *Secondary containment requirements for new and replacement UST system installations.* All new and replacement underground storage tank systems and appurtenances used for the storage and dispensing of petroleum products installed after November 28, 2007, shall have secondary containment in accordance with this subrule. The secondary containment provision includes the installation of turbine sumps, transition or intermediate sumps and under-dispenser containment (UDC).

a. The secondary containment may be manufactured as an integral part of the primary containment or constructed as a separate containment system.

b. Installation of any new or replacement turbine pumps involving the direct connection to the tank shall have secondary containment.

c. Any replacement of ten feet or more of piping shall have secondary containment.

d. All piping replacements requiring secondary containment shall be constructed with transition or intermediate containment sumps.

e. The design and construction of all primary and secondary containment shall meet the performance standards in subrule 135.3(1) and paragraphs 135.5(3)*"b"* and 135.5(4)*"g."* At a minimum, the secondary containment must:

(1) Contain regulated substances released from the tank system until detected and removed;

(2) Prevent the release of regulated substances into the environment at any time during the operational life of the underground storage tank system; and

(3) Be checked for evidence of a release at least every 30 days as provided in paragraph 135.5(2)*"a."*

f. Secondary containment with interstitial monitoring in accordance with paragraphs 135.5(3)*"b,"* 135.5(4)*"g"* and 135.5(5)*"d"* shall become the primary method of leak detection for all new and replacement tanks and piping installed after November 28, 2007.

g. Testing and inspection. Secondary containment systems shall be liquid-tight and must be inspected and tested every two years. The sensing devices must be tested every two years.

(1) Inspections for secondary containment sumps (spill catchment basins, turbine sumps, transition or intermediate sumps, and under-dispenser containment) shall:

1. Consist of a visual inspection by an Iowa-licensed installer or Iowa-certified inspector every two years. Sumps must be intact (no cracks or perforations) and liquid-tight, including sides and bottom.

2. Sumps must be maintained and kept free of debris, liquid and ice at all times.

3. Regulated substances spilled into any spill catchment basin, turbine sump, transition/intermediate sump or under-dispenser containment shall be immediately removed.

(2) Sensing devices used to monitor the interstitial space shall be tested at least every two years for proper function.

h. Under-dispenser containment. When installing a new motor fuel dispenser or replacing a motor fuel dispenser, a UDC shall be installed whenever:

(1) A motor fuel dispenser is installed at a location where there previously was no dispenser (new UST system or new dispenser location at an existing UST system); or

(2) An existing motor fuel dispenser is removed and replaced with another dispenser and the equipment used to connect the dispenser to the underground storage tank system is replaced. This equipment includes flexible connectors or risers or other transitional components that are beneath the dispenser and connect the dispenser to the piping. A UDC is not required when only the emergency shutoff or shear valves or check valves are replaced.

(3) A UDC shall also be installed beneath the motor fuel dispenser whenever ten feet or more of piping is repaired or replaced within ten feet of a motor fuel dispenser.

i. Exceptions from secondary containment standards. A tank owner or operator may request an exception from the secondary containment standard if the location of the UST system is greater than 1,000 feet from a community water system or potable drinking water well. A community water system includes the distribution piping.

(1) "Community water system (CWS)" means a public water system which has at least 15 service connections used by year-round residents or regularly serves at least 25 year-round residents. "Public water supply system" means a system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year. Such term includes: any collection, treatment, storage, and distribution facilities under control of the operator of such system and used primarily in connection with such system; and any collection or pretreatment storage facilities not under such control which are used primarily in connection with such system. Such term does not include any "special irrigation district." A "public water supply system" is either a "community water system" or a "noncommunity water system."

(2) "Potable drinking water well" means any hole (dug, driven, drilled, or bored) that extends into the earth until it meets groundwater and that supplies water for a noncommunity public water system or supplies water for household use (consisting of drinking, bathing, and cooking or other similar uses). Such wells may provide water to entities such as a single-family residence, a group of residences, businesses, schools, parks, campgrounds, and other permanent or seasonal communities. A "noncommunity water system" is defined in rule 567—40.2(455B) as a public water system that is not a community water system. A "noncommunity water system" is either a "transient noncommunity water system (TNC)" or a "nontransient noncommunity water system (NTNC)."

(3) To determine if a new or replacement underground storage tank, piping, or motor fuel dispenser system is within 1,000 feet of an existing community water system or an existing potable drinking water well, at a minimum the distance must be measured from the closest part of the new or replacement underground storage tank or piping or the motor fuel dispenser system to:

1. The closest part of the nearest existing community water system, including:

- The location of the wellhead(s) for groundwater and the location of the intake point(s) for surface water;
- Water lines, processing tanks, and water storage tanks; and
- Water distribution/service lines under the control of the community water system operator.

2. The wellhead of the nearest existing potable drinking water well.

(4) If a new or replacement underground storage tank, piping, or motor fuel dispenser that is not within 1,000 feet of an existing community water system will be installed, and a community water system that will be within 1,000 feet of the UST system is planned or a permit application has been submitted to the department under 567—Chapter 40, secondary containment and under-dispenser containment are required unless the permit is denied.

(5) If a new or replacement underground storage tank, piping, or motor fuel dispenser that is not within 1,000 feet of an existing potable drinking water well will be installed and the owner will be installing a potable drinking water well at the new facility, or a private water well permit has been submitted pursuant to 567—Chapter

38 and pursuant to applicable county and municipal ordinances for a potable drinking water well that will be within 1,000 feet of the UST system, secondary containment and under-dispenser containment are required unless the permit is denied.

j. Documentation for exception from secondary containment. The following documentation must be provided by the tank owner or operator when requesting an exception from the UST system secondary containment requirement.

(1) A statement from the manager of the local community water system that the community water system is not located or planned within 1,000 feet of the UST system location. This would include rural water systems.

(2) A map showing homes and businesses within 1,000 feet of the UST system location.

(3) Identification of the source of water for the business at the UST system location.

(4) The results of an on-foot search around businesses and homes within a 1,000-foot radius for possible potable drinking water wells. Documentation that there are no pending nonpublic water well permit applications within 1,000 feet of the UST system from any applicable municipal permitting authority, county department of health with department-delegated authority, or the department if there is not delegated permitting authority.

(5) Search results from the Geographic Information System (GIS) well mapping for well locations available from the Iowa Geological Survey.

(6) Documentation that the department's water supply section has no pending applications for a public water supply construction permit within 1,000 feet of a proposed UST system installation or replacement or motor fuel dispenser installation or replacement.

567—135.4(455B) General operating requirements.

135.4(1) *Spill and overfill control.*

a. Owners and operators must ensure that releases due to spilling or overfilling do not occur. The owner and operator must ensure that the volume available in the tank is greater than the volume of product to be transferred to the tank before the transfer is made and that the transfer operation is monitored constantly to prevent overfilling and spilling.

NOTE: The transfer procedures described in National Fire Protection Association Publication 385 may be used to comply with 135.4(1)*"a."* Further guidance on spill and overfill prevention appears in American Petroleum Institute Publication 1621, "Recommended Practice for Bulk Liquid Stock Control at Retail Outlets," and National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code."

b. The owner and operator must report, investigate, and clean up any spills and overfills in accordance with 135.6(4).

135.4(2) *Operation and maintenance of corrosion protection.* All owners and operators of steel UST systems with corrosion protection must comply with the following requirements to ensure that releases due to corrosion are prevented for as long as the UST system is used to store regulated substances:

a. All corrosion protection systems must be operated and maintained to continuously provide corrosion protection to the metal components of that portion of the tank and piping that routinely contain regulated substances and are in contact with the ground.

b. All UST systems equipped with cathodic protection systems must be inspected for proper operation by a qualified cathodic protection tester in accordance with the following requirements:

(1) *Frequency.* All cathodic protection systems must be tested within six months of installation and at least every three years thereafter or according to another reasonable time frame established by the department; and

(2) *Inspection criteria.* The criteria that are used to determine that cathodic protection is adequate as required by this subrule must be in accordance with a code of practice developed by a nationally recognized association.

NOTE: National Association of Corrosion Engineers Standard RP-02-85, "Control of External Corrosion on Metallic Buried, Partially Buried, or Submerged Liquid Storage Systems," may be used to comply with 135.4(2)*"b"*(2).

c. UST systems with impressed current cathodic protection systems must also be inspected every 60 days to ensure the equipment is running properly.

d. For UST systems using cathodic protection, records of the operation of the cathodic protection must be maintained (in accordance with 135.4(5)) to demonstrate compliance with the performance standards in this subrule. These records must provide the following:

(1) The results of the last three inspections required in paragraph *"c"*; and

(2) The results of testing from the last two inspections required in paragraph *"b."*

135.4(3) *Compatibility.* Owners and operators must use a UST system made of or lined with materials that are compatible with the substance stored in the UST system.

NOTE: Owners and operators storing alcohol blends may use the following codes to comply with the requirements of subrule 135.4(3): American Petroleum Institute Publication 1626, "Storing and Handling Ethanol and Gasoline-Ethanol Blends at Distribution Terminals and Service Stations"; and American Petroleum Institute Publication 1627, "Storage and Handling of Gasoline-Methanol/Cosolvent Blends at Distribution Terminals and Service Stations."

135.4(4) *Repairs allowed.* Owners and operators of UST systems must ensure that repairs will prevent releases due to structural failure or corrosion as long as the UST system is used to store regulated substances. The repairs must meet the following requirements:

a. Repairs to UST systems must be properly conducted in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory.

NOTE: The following codes and standards may be used to comply with 135.4(4)*"a"*: National Fire Protection Association Standard 30, "Flammable and Combustible Liquids Code"; American Petroleum Institute Publication 2200, "Repairing Crude Oil, Liquified Petroleum Gas, and Product Pipelines"; American Petroleum Institute Publication 1631, "Recommended Practice for the Interior Lining of Existing Steel Underground Storage Tanks"; and National Leak Prevention Association Standard 631, "Spill Prevention, Minimum 10 Year Life Extension of Existing Steel Underground Tanks by Lining Without the Addition of Cathodic Protection."

b. Repairs to fiberglass-reinforced plastic tanks may be made by the manufacturer's authorized representatives or in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory.

c. Metal pipe sections and fittings that have released product as a result of corrosion or other damage must be replaced. Fiberglass pipes and fittings may be repaired in accordance with the manufacturer's specifications.

d. Repaired tanks and piping must be tightness tested in accordance with 135.5(4)*"c"* and 135.5(5)*"b"* within 30 days following the date of the completion of the repair except as provided in subparagraphs (1) to (3) below:

(1) The repaired tank is internally inspected in accordance with a code of practice developed by a nationally recognized association or an independent testing laboratory; or

(2) The repaired portion of the UST system is monitored monthly for releases in accordance with a method specified in 135.5(4)*"d"* through *"h"*; or

(3) Another test method is used that is determined by the department to be no less protective of human health and the environment than those listed above.

e. Within six months following the repair of any cathodically protected UST system, the cathodic protection system must be tested in accordance with 135.4(2)*"b"* and *"c"* to ensure that it is operating properly.

f. UST system owners and operators must maintain records of each repair for the remaining operating life of the UST system that demonstrate compliance with the requirements of this subrule.

135.4(5) *Reporting and record keeping.* Owners and operators of UST systems must cooperate fully with inspections, monitoring and testing conducted by the department, as well as requests for document submission, testing, and monitoring by the owner or operator pursuant to Section 9005 of Subtitle I of the Resource Conservation and Recovery Act, as amended.

a. Reporting. Owners and operators must submit the following information to the department:

(1) Notification for all UST systems (135.3(3)), which includes certification of installation for new UST systems (135.3(1)*"e"*);

(2) Reports of all releases including suspected releases (135.6(1)), spills and overfills (135.6(4)), and confirmed releases (135.7(2));

(3) Corrective actions planned or taken including initial abatement measures (135.7(3)), initial site characterization (135.9(455B)), free product removal (135.7(5)), investigation of soil and groundwater cleanup and corrective action plan (135.8(455B) to 135.12(455B)); and

(4) A notification before permanent closure or change-in-service (135.15(2)).

b. Record keeping. Owners and operators must maintain the following information:

(1) A corrosion expert's analysis of site corrosion potential if corrosion protection equipment is not used (135.3(1)*"a"*(4); (135.3(1)*"b"*(3)).

(2) Documentation of operation of corrosion protection equipment (135.4(2));

(3) Documentation of UST system repairs (135.4(4)*"f"*);
(4) Recent compliance with release detection requirements (135.5(6)); and
(5) Results of the site investigation conducted at permanent closure (135.15(5)).
c. Availability and maintenance of records. Owners and operators must keep the records required either:
(1) At the UST site and immediately available for inspection by the department; or
(2) At a readily available alternative site and be provided for inspection to the department upon request.
NOTE: In the case of permanent closure records required under 135.15(5), owners and operators are also provided with the additional alternative of mailing closure records to the department if they cannot be kept at the site or an alternative site as indicated above.

567—135.5(455B) Release detection.
135.5(1) *General requirements for all UST systems.*
a. Owners and operators of new and existing UST systems must provide a method, or combination of methods, of release detection that:
(1) Can detect a release from any portion of the tank and the connected underground piping that routinely contains product;
(2) Is installed, calibrated, operated, and maintained in accordance with the manufacturer's instructions, including routine maintenance and service checks for operability or running condition; and
(3) Meets the performance requirements in 135.5(4) or 135.5(5), with any performance claims and their manner of determination described in writing by the equipment manufacturer or installer. In addition, methods conducted in accordance with 135.5(4)*"b," "c,"* and *"d"* and 135.5(5)*"b"* after December 22, 1990, and 135.5(5)*"a"* after September 22, 1991, except for methods permanently installed prior to those dates, must be capable of detecting the leak rate or quantity specified for that method with a probability of detection of 0.95 and a probability of false alarm of 0.05.
b. When a release detection method operated in accordance with the performance standards in 135.5(4) and 135.5(5) indicates a release may have occurred, owners and operators must notify the department in accordance with rule 135.6(455B).
c. Owners and operators of all UST systems must comply with the release detection requirements of this rule by December 22 of the year listed in the following table:

Scheduled for Phase-in of Release Detection					
Year System Was Installed	Year When Release Detection is Required (by December 22 of the Year Indicated)				
	1989	1990	1991	1992	1993
Before 1965 or Date Unknown	RD	P			
1965-1969		P/RD			
1970-1974		P	RD		
1975-1979		P		RD	
1980-1988		P			RD
New Tanks	Immediately upon installation				

P = Must begin release detection for all pressurized piping in accordance with 135.5(2)*"b"*(1).
RD = Must begin release detection for tanks and suction piping in accordance with 135.5(2)*"a,"* 135.5(2)*"b"*(2), and 135.5(3).

d. Any existing UST system that cannot apply a method of release detection that complies with the requirements of this rule must complete the closure procedures in rule 135.15(455B) by the date on which release detection is required for that UST system under paragraph *"c."*
135.5(2) *Requirements for petroleum UST systems.* Owners and operators of petroleum UST systems must provide release detection for tanks and piping as follows:
a. Tanks. Tanks must be monitored at least every 30 days for releases using one of the methods listed in 135.5(4)*"d"* to *"h"* except that:

(1) UST systems that meet the performance standards in 135.3(1) or 135.3(2), and the monthly inventory control requirements in 135.5(4)*"a"* or *"b,"* may use tank tightness testing (conducted in accordance with 135.5(4)*"c"*) at least every five years until December 22, 1998, or until ten years after the tank is installed or upgraded under 135.3(2)*"b,"* whichever is later;

(2) UST systems that do not meet the performance standards in 135.3(1) or 135.3(2) may use monthly inventory controls (conducted in accordance with 135.5(4)*"a"* or *"b"*) and annual tank tightness testing (conducted in accordance with 135.5(4)*"c"*) until December 22, 1998, when the tank must be upgraded under 135.3(2) or permanently closed under 135.15(2); and

(3) Tanks with capacity of 550 gallons or less may use weekly tank gauging (conducted in accordance with 135.5(4)*"b"*).

b. Piping. Underground piping that routinely contains regulated substances must be monitored for releases in a manner that meets one of the following requirements:

(1) *Pressurized piping.* Underground piping that conveys regulated substances under pressure must:

1. Be equipped with an automatic line leak detector conducted in accordance with 135.5(5)*"a"*; and

2. Have an annual line tightness test conducted in accordance with 135.5(5)*"b"* or have monthly monitoring conducted in accordance with 135.5(5)*"c."*

(2) *Suction piping.* Underground piping that conveys regulated substances under suction must either have a line tightness test conducted at least every three years and in accordance with 135.5(5)*"b,"* or use a monthly monitoring method conducted in accordance with 135.5(5)*"c."* No release detection is required for suction piping that is designed and constructed to meet the following standards:

1. The below-grade piping operates at less than atmospheric pressure;

2. The below-grade piping is sloped so that the contents of the pipe will drain back into the storage tank if the suction is released;

3. Only one check valve is included in each suction line;

4. The check valve is located directly below and as close as practical to the suction pump; and

5. A method is provided that allows compliance with "2" through "4" to be readily determined.

135.5(3) *Requirements for hazardous substance UST systems.* Owners and operators of hazardous substance UST systems must provide release detection that meets the following requirements:

a. Release detection at existing UST systems must meet the requirements for petroleum UST systems in 135.5(2). By December 22, 1998, all existing hazardous substance UST systems must meet the release detection requirements for new systems in paragraph *"b"* below.

b. Release detection at new hazardous substance UST systems must meet the following requirements:

(1) Secondary containment systems must be designed, constructed and installed to:

1. Contain regulated substances released from the tank system until they are detected and removed;

2. Prevent the release of regulated substances to the environment at any time during the operational life of the UST system; and

3. Be checked for evidence of a release at least every 30 days.

NOTE: The provisions of 40 CFR 265.193, Containment and Detection of Releases, as of September 13, 1988, may be used to comply with these requirements.

(2) Double-walled tanks must be designed, constructed, and installed to:

1. Contain a release from any portion of the inner tank within the outer wall; and

2. Detect the failure of the inner wall.

(3) External liners (including vaults) must be designed, constructed, and installed to:

1. Contain 100 percent of the capacity of the largest tank within its boundary;

2. Prevent the interference of precipitation or groundwater intrusion with the ability to contain or detect a release of regulated substances; and

3. Surround the tank completely (i.e., it is capable of preventing lateral as well as vertical migration of regulated substances).

(4) Underground piping must be equipped with secondary containment that satisfies the requirements of 135.5(3)*"b"*(1) above (e.g., trench liners, jacketing of double-walled pipe). In addition, underground piping that conveys regulated substances under pressure must be equipped with an automatic line leak detector in accordance with 135.5(5)*"a"*;

(5) Other methods of release detection may be used if owners and operators:

1. Demonstrate to the department that an alternate method can detect a release of the stored substance as effectively as any of the methods allowed in 135.5(4)*"b"* to *"h"* can detect a release of petroleum;

2. Provide information to the department on effective corrective action technologies, health risks, and chemical and physical properties of the stored substance, and the characteristics of the UST site; and

3. Obtain approval from the department to use the alternate release detection method before the installation and operation of the new UST system.

135.5(4) *Methods of release detection for tanks.* Each method of release detection for tanks used to meet the requirements of 135.5(2) must be conducted in accordance with the following:

a. Inventory control. Product inventory control (or another test of equivalent performance) must be conducted monthly to detect a release of at least 1.0 percent of flow-through plus 130 gallons on a monthly basis in the following manner:

(1) Inventory volume measurements for regulated substance inputs, withdrawals, and the amount still remaining in the tank are recorded each operating day;

(2) The equipment used is capable of measuring the level of product over the full range of the tank's height to the nearest 1/8 of an inch;

(3) The regulated substance inputs are reconciled with delivery receipts by measurement of the tank inventory volume before and after delivery;

(4) Deliveries are made through a drop tube that extends to within 1 foot of the tank bottom;

(5) Product dispensing is metered and recorded within the local standards for meter calibration or an accuracy of 6 cubic inches for every 5 gallons of product withdrawn; and

(6) The measurement of any water level in the bottom of the tank is made to the nearest 1/8 of an inch at least once a month.

NOTE: Practices described in the American Petroleum Institute Publication 1621, "Recommended Practice for Bulk Liquid Stock Control at Retail Outlets," may be used, where applicable, as guidance in meeting the requirements of subrule 135.5(4), paragraph *"a,"* subparagraphs (1) to (6).

b. Manual tank gauging. Manual tank gauging must meet the following requirements:

(1) Tank liquid level measurements are taken at the beginning and ending of a period of at least 36 hours during which no liquid is added to or removed from the tank;

(2) Level measurements are based on an average of two consecutive stick readings at both the beginning and ending of the period;

(3) The equipment used is capable of measuring the level of product over the full range of the tank's height to the nearest 1/8 of an inch;

(4) A leak is suspected and subject to the requirements of rule 135.6(455B) if the variation between beginning and ending measurements exceeds the weekly or monthly standards in the following table:

Nominal Tank Capacity	Weekly Standard (one test)	Monthly Standard (average of four tests)
550 gallons or less	10 gallons	5 gallons
551-1,000 gallons	13 gallons	7 gallons
1,001-2,000 gallons	26 gallons	13 gallons

(5) Only tanks of 550 gallons or less nominal capacity may use this as the sole method of release detection. Tanks of 551 to 2000 gallons may use the method in place of manual inventory control in 135.5(4)*"a."* Tanks of greater than 2000 gallons nominal capacity may not use this method to meet the requirements of this rule.

c. Tank tightness testing. Tank tightness testing (or another test of equivalent performance) must be capable of detecting a 0.1 gallon-per-hour leak rate from any portion of the tank that routinely contains product while accounting for the effects of thermal expansion or contraction of the product, vapor pockets, tank deformation, evaporation or condensation, and the location of the water table.

d. Automatic tank gauging. Equipment for automatic tank gauging that tests for the loss of product and conducts inventory control must meet the following requirements:

(1) The automatic product level monitor test can detect a 0.2 gallon-per-hour leak rate from any portion of the tank that routinely contains product; and

(2) Inventory control (or another test of equivalent performance) is conducted in accordance with the requirements of 135.5(4)*"a."*

e. Vapor monitoring. Testing or monitoring for vapors within the soil gas of the excavation zone must meet the following requirements:

(1) The materials used as backfill are sufficiently porous (e.g., gravel, sand, crushed rock) to readily allow diffusion of vapors from releases into the excavation area;

(2) The stored regulated substance, or a tracer compound placed in the tank system, is sufficiently volatile (e.g., gasoline) to result in a vapor level that is detectable by the monitoring devices located in the excavation zone in the event of a release from the tank;

(3) The measurement of vapors by the monitoring device is not rendered inoperative by the groundwater, rainfall, or soil moisture or other known interferences so that a release could go undetected for more than 30 days;

(4) The level of background contamination in the excavation zone will not interfere with the method used to detect releases from the tank;

(5) The vapor monitors are designed and operated to detect any significant increase in concentration above background of the regulated substance stored in the tank system, a component or components of that substance, or a tracer compound placed in the tank system;

(6) In the UST excavation zone, the site is assessed to ensure compliance with the requirements in 135.5(4)*"e"*(1) to (4) and to establish the number and positioning of monitoring wells that will detect releases within the excavation zone from any portion of the tank that routinely contains product; and

(7) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

f. Groundwater monitoring. Testing or monitoring for liquids on the groundwater must meet the following requirements:

(1) The regulated substance stored is immiscible in water and has a specific gravity of less than 1;

(2) Groundwater is never more than 20 feet from the ground surface and the hydraulic conductivity of the soil(s) between the UST system and the monitoring wells or devices is not less than 0.01 cm/sec (e.g., the soil should consist of gravels, coarse to medium sands, coarse silts or other permeable materials);

(3) The slotted portion of the monitoring well casing must be designed to prevent migration of natural soils or filter pack into the well and to allow entry of regulated substance on the water table into the well under both high and low groundwater conditions;

(4) Monitoring wells shall be sealed from the ground surface to the top of the filter pack;

(5) Monitoring wells or devices intercept the excavation zone or are as close to it as is technically feasible;

(6) The continuous monitoring devices or manual methods used can detect the presence of at least 1/8 of an inch of free product on top of the groundwater in the monitoring wells;

(7) Within and immediately below the UST system excavation zone, the site is assessed to ensure compliance with the requirements in 135.5(4)*"f"*(1) to (5) and to establish the number and positioning of monitoring wells or devices that will detect releases from any portion of the tank that routinely contains product; and

(8) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

g. Interstitial monitoring. Interstitial monitoring between the UST system and a secondary barrier immediately around or beneath it may be used, but only if the system is designed, constructed and installed to detect a leak from any portion of the tank that routinely contains product and also meets one of the following requirements:

(1) For secondary containment systems, the sampling or testing method must be able to detect a release through the inner wall in any portion of the tank that routinely contains product:

1. Continuously, by means of an automatic leak sensing device that signals to the operator the presence of any regulated substance in the interstitial space; or

2. Monthly, by means of a procedure capable of detecting the presence of any regulated substance in the interstitial space.

3. The interstitial space shall be maintained and kept free of liquid, debris or anything that could interfere with leak detection capabilities.

NOTE: The provisions outlined in the Steel Tank Institute's "Standard for Dual Wall Underground Storage Tanks" may be used as guidance for aspects of the design and construction of underground steel double-walled tanks.

(2) For UST systems with a secondary barrier within the excavation zone, the sampling or testing method used can detect a release between the UST system and the secondary barrier:

1. The secondary barrier around or beneath the UST system consists of artificially constructed material that is sufficiently thick and impermeable (at least 10^{-6} cm/sec for the regulated substance stored) to direct a release to the monitoring point and permit its detection;

2. The barrier is compatible with the regulated substance stored so that a release from the UST system will not cause a deterioration of the barrier allowing a release to pass through undetected;

3. For cathodically protected tanks, the secondary barrier must be installed so that it does not interfere with the proper operation of the cathodic protection system;

4. The groundwater, soil moisture, or rainfall will not render the testing or sampling method used inoperative so that a release could go undetected for more than 30 days;

5. The site is assessed to ensure that the secondary barrier is always above the groundwater and not in a 25-year flood plain, unless the barrier and monitoring designs are for use under such conditions; and

6. Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.

(3) For tanks with an internally fitted liner, an automated device can detect a release between the inner wall of the tank and the liner, and the liner is compatible with the substance stored.

h. Other methods. Any other type of release detection method, or combination of methods, can be used if:

(1) It can detect a 0.2 gallon-per-hour leak rate or a release of 150 gallons within a month with a probability of detection of 0.95 and a probability of false alarm of 0.05; or

(2) The department may approve another method if the owner and operator can demonstrate that the method can detect a release as effectively as any of the methods allowed in paragraphs *"c"* to *"h."* In comparing methods, the department shall consider the size of release that the method can detect and the frequency and reliability with which it can be detected. If the method is approved, the owner and operator must comply with any conditions imposed by the department on its use to ensure the protection of human health and the environment.

135.5(5) *Methods of release detection for piping.* Each method of release detection for piping used to meet the requirements of 135.5(2) must be conducted in accordance with the following:

a. Automatic line leak detectors. Methods which alert the operator to the presence of a leak by restricting or shutting off the flow of regulated substances through piping or triggering an audible or visual alarm may be used only if they detect leaks of 3 gallons per hour at 10 pounds per square inch line pressure within one hour. An annual test of the operation of the leak detector must be conducted in accordance with the manufacturer's requirements.

b. Line tightness testing. A periodic test of piping may be conducted only if it can detect a 0.1 gallon-per-hour leak rate at one and one-half times the operating pressure.

c. Applicable tank methods. Any of the methods in 135.5(4)*"e"* through *"h"* may be used if they are designed to detect a release from any portion of the underground piping that routinely contains regulated substances.

d. Interstitial monitoring of secondary containment. Interstitial monitoring may be used for any piping with secondary containment designed for and capable of interstitial monitoring.

(1) Leak detection shall be conducted:

1. Continously, by means of an automatic leak sensing device that signals to the operator the presence of any regulated substance in the interstitial space or containment sump; or

2. Monthly, by means of a procedure capable of detecting the presence of any regulated substance in the interstitial space or containment sump, such as visual inspection.

(2) The interstitial space or sump shall be maintained and kept free of water, debris or anything that could interfere with leak detection capabilities.

(3) At least every two years, any sump shall be visually inspected for integrity of sides and floor and tightness of piping penetration seals. Any automatic sensing device shall be tested for proper function.

135.5(6) *Release detection record keeping.* All UST system owners and operators must maintain records in accordance with 135.4(5) demonstrating compliance with all applicable requirements of this rule. These records must include the following:

a. All written performance claims pertaining to any release detection system used, and the manner in which these claims have been justified or tested by the equipment manufacturer or installer, must be maintained for five years, or for another reasonable period of time determined by the department, from the date of installation;

b. The results of any sampling, testing, or monitoring must be maintained for at least one year, or for another reasonable period of time determined by the department, except that the results of tank tightness testing conducted in accordance with 135.5(4)*"c"* must be retained until the next test is conducted; and

c. Written documentation of all calibration, maintenance, and repair of release detection equipment permanently located on-site must be maintained for at least one year after the servicing work is completed, or for another reasonable time period determined by the department. Any schedules of required calibration and maintenance provided by the release detection equipment manufacturer must be retained for five years from the date of installation.

567—135.6(455B) Release reporting, investigation, and confirmation.

135.6(1) *Reporting of suspected releases.* Owners and operators of UST systems must report to the department within 24 hours, or within 6 hours in accordance with 567—Chapter 131 if a hazardous condition exists as defined in 567—131.1(455B), or another reasonable time period specified by the department, and follow the procedures in 135.8(1) for any of the following conditions:

a. The discovery by owners and operators or others of released regulated substances at the UST site or in the surrounding area (such as the presence of free product or vapors in soils, basements, sewer and utility lines, and nearby surface water);

b. Unusual operating conditions observed by owners and operators (such as the erratic behavior of product dispensing equipment, the sudden loss of product from the UST system, or an unexplained presence of water in the tank), unless system equipment is found to be defective but not leaking, and is immediately repaired or replaced; and

c. Monitoring results from a release detection method required under 135.5(2) and 135.5(3) that indicate a release may have occurred unless:

(1) The monitoring device is found to be defective, and is immediately repaired, recalibrated or replaced, and additional monitoring does not confirm the initial result; or

(2) In the case of inventory control, a second month of data does not confirm the initial result.

135.6(2) *Investigation due to off-site impacts.* When required by the department, owners and operators of UST systems must follow the procedures in 135.6(3) to determine if the UST system is the source of off-site impacts. These impacts include the discovery of regulated substances (such as the presence of free product or vapors in soils, basements, sewer and utility lines, and nearby surface and drinking waters) that has been observed by the department or brought to its attention by another party.

135.6(3) *Release investigation and confirmation steps.* Owners and operators must immediately investigate and confirm all suspected releases of regulated substances requiring reporting under 135.6(1) within seven days, or another reasonable time period specified by the department, using either the following steps or another procedure approved by the department:

a. System test. Owners and operators must conduct tests (according to the requirements for tightness testing in 135.5(4)*"c"* and 135.5(5)*"b"*) that determine whether a leak exists in that portion of the tank that routinely contains product, or the attached delivery piping or both.

(1) Owners and operators must repair, replace or upgrade the UST system and begin corrective action in accordance with rule 135.9(455B) if the test results for the system, tank, or delivery piping indicate a leak exists.

(2) Further investigation is not required if the test results for the system, tank, and delivery piping do not indicate a leak exists and if environmental contamination is not the basis for suspecting a release.

(3) Owners and operators must conduct a site check as described in paragraph *"b"* of this subrule if the test results for the system, tank, and delivery piping do not indicate a leak exists but environmental contamination is the basis for suspecting a release.

b. Site check. A certified groundwater professional must conduct a site check in accordance with the tank closure in place procedures as provided in 135.15(3) or they may conduct a Tier 1 assessment in accordance with subrule 135.9(3). Under either procedure, the certified groundwater professional must follow the policies and procedures applicable to sites where bedrock is encountered before groundwater as provided in 135.8(5) to avoid creating a preferential pathway for soil or groundwater contamination to reach a bedrock aquifer. The certified groundwater professional must measure for the presence of a release where contamination is most likely to be present at the UST site. In selecting sample types, sample locations, and measurement methods, the certified groundwater professional must consider the nature of the stored substance, the type of initial alarm or cause for

suspicion, the type of backfill, the depth of groundwater, and other factors appropriate for identifying the presence and source of the release.

(1) If the test results of the site check indicate action levels in 135.14(455B) have been exceeded, owners and operators must begin corrective action in accordance with rules 135.7(455B) to 135.12(455B).

(2) If the test results for the excavation zone or the UST site do not indicate a release has occurred, further investigation is not required.

135.6(4) *Reporting and cleanup of spills and overfills.*

a. Reportable releases. Owners and operators of UST systems must contain and immediately clean up a spill, overfill or any aboveground release, and report to the department within 24 hours, or within 6 hours in accordance with 567—Chapter 131 if a hazardous condition exists as defined in rule 567—131.1(455B) and begin corrective action in accordance with rules 135.7(455B) to 135.12(455B) in the following cases:

(1) Spill, overfill or any aboveground release of petroleum that results in a release to the environment that exceeds 25 gallons, causes a sheen on nearby surface water, impacts adjacent property, or contaminates groundwater; and

(2) Spill, overfill or any aboveground release of a hazardous substance that results in a release to the environment that equals or exceeds its reportable quantity under CERCLA (40 CFR 302) as of September 13, 1988.

b. Nonreportable releases. Owners and operators of UST systems must contain and immediately clean up a spill, overfill or any aboveground release of petroleum that is less than 25 gallons and a spill, overfill or any aboveground release of a hazardous substance that is less than the reportable quantity. If cleanup cannot be accomplished within 24 hours, owners and operators must immediately notify the department.

NOTE: Any spill or overfill that results in a hazardous condition as defined in rule 567—131.1(455B) must be reported within 6 hours. This includes the transporter of the product. A release of a hazardous substance equal to or in excess of its reportable quantity must also be reported immediately (rather than within 24 hours) to the National Response Center under Sections 102 and 103 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 and to appropriate state and local authorities under Title III of the Superfund Amendments and Reauthorization Act of 1986.

567—135.7(455B) Release response and corrective action for UST systems containing petroleum or hazardous substances.

135.7(1) *General.* Owners and operators of petroleum or hazardous substance UST systems must, in response to a confirmed release from the UST system, comply with the requirements of this rule except for USTs excluded under 135.1(3)*"b"* and UST systems subject to RCRA Subtitle C corrective action requirements under Section 3004(u) of the Resource Conservation and Recovery Act, as amended.

135.7(2) *Initial response.* Upon confirmation of a release in accordance with 135.6(3) or after a release from the UST system is identified in any other manner, owners and operators must perform the following initial response actions within 24 hours of a release or within another reasonable period of time specified by the department:

a. Report the release to the department (e.g., by telephone or electronic mail);

b. Take immediate action to prevent any further release of the regulated substance into the environment; and

c. Identify and mitigate fire, explosion, and vapor hazards.

135.7(3) *Initial abatement measures and site check.*

a. Unless directed to do otherwise by the department, owners and operators must perform the following abatement measures:

(1) Remove as much of the regulated substance from the UST system as is necessary to prevent further release to the environment;

(2) Visually inspect any aboveground releases or exposed below-ground releases and prevent further migration of the released substance into surrounding soils and groundwater;

(3) Continue to monitor and mitigate any additional fire and safety hazards posed by vapors or free product that have migrated from the UST excavation zone and entered into subsurface structures (such as sewers or basements);

(4) Remedy hazards posed by contaminated soils that are excavated or exposed as a result of release confirmation, site investigation, abatement, or corrective action activities. If these remedies include treatment or disposal of soils, the owner and operator must comply with applicable state and local requirements;

(5) Rescinded IAB 7/17/96, effective 8/15/96.

(6) Investigate to determine the possible presence of free product, and begin free product removal as soon as practicable and in accordance with 135.7(5).

b. Within 20 days after release confirmation, or within another reasonable period of time determined by the department, owners and operators must submit a report to the department summarizing the initial abatement steps taken under paragraph *"a"* and any resulting information or data.

135.7(4) *Initial site characterization.* Rescinded IAB 7/17/96, effective 8/15/96.

135.7(5) *Free product assessment and removal.* At sites where investigations under 135.7(3)*"a"*(6) indicate 0.01 ft. or more of free product, owners and operators must immediately initiate a free product recovery assessment and submit a report in accordance with paragraph *"d"* and initiate interim free product removal while continuing, as necessary, any actions initiated under 135.7(2) to 135.7(4), or preparing for actions required under 135.8(455B) to 135.12(455B). Owners and operators must immediately begin interim free product removal by bailing or by installation and maintenance of passive skimming equipment until an alternative removal method is required by or approved by the department. A certified groundwater professional must initially determine the frequency of bailing and proper installation and maintenance of the skimming equipment based on a determination of the recharge rate of the free product. The department may approve implementation of this interim removal process by persons not certified as groundwater professionals. For approval a certified groundwater professional must submit (1) sufficient documentation establishing that the bailing or skimming system has been adequately designed and tested, and (2) a written plan for regular maintenance, reporting and supervision by a certified groundwater professional. Interim free product recovery reports must be submitted to the department on a monthly basis and on forms provided by the department. In meeting the requirements of this subrule, owners and operators must:

a. Conduct free product removal at a frequency determined by the recharge rate of the product and in a manner that minimizes the spread of contamination into previously uncontaminated zones by using recovery and disposal techniques appropriate to the hydrogeologic conditions at the site, and that properly treats, discharges or disposes of recovery by-products in compliance with applicable local, state and federal regulations. Unless approved by the department, free product assessment and recovery activities must be conducted by a certified groundwater professional. Owners and operators must report the results of free product removal activities on forms designated by the department;

b. Use abatement of free product migration as a minimum objective for the design of the free product removal system. Free product recovery systems must be designed to remove free product to the maximum extent practicable;

c. Handle any flammable products in a safe and competent manner to prevent fires or explosions; and

d. Free product recovery assessment and report. Unless directed to do otherwise by the department, prepare and submit to the department, within 45 days after confirming a release, a free product recovery assessment report and a proposal for subsequent free product removal activities. The free product recovery assessment report and removal proposal must contain at least the following information:

(1) The name of the person(s) responsible for implementing the free product removal measures;

(2) The estimated quantity, type and thickness of free product observed or measured in monitoring wells, boreholes, and excavations, the recharge rate in all affected monitoring wells and a detailed description of the procedures used to determine the recharge rate;

(3) A detailed justification for the free product removal technology proposed for the site. Base the justification narrative on professional judgment considering the characteristics of the free product plume (i.e., estimated volume, type of product, thickness, extent), an assessment of cost effectiveness based on recovery costs compared to alternative methods, site hydrology and geology, when the release event occurred, testing conducted to verify design assumptions and the potential for petroleum vapors or explosive conditions to occur in enclosed spaces. Proposals for removal systems other than hand bailing or passive skimming systems must be completed and submitted on a format consistent with the department's corrective action design report.

(4) A schematic and narrative description of the free product recovery system used;

(5) Whether any discharge will take place on site or off site during the recovery operation and where this discharge will be located;

(6) A schematic and narrative description of the treatment system, and the effluent quality expected from any discharge;

(7) The steps that have been or are being taken to obtain necessary permits for any discharge;

(8) The disposition of the recovered free product;

(9) Free product plume definition and map. The extent of free product in groundwater must be assessed. The number and location of wells and separation distance between the wells used to define the free product plume must be based on the receptors present and the site hydrology and geology. A minimum of five monitoring wells are required to construct the plume map. If the groundwater professional can adequately define the plume using other technology as specified in department guidance, fewer than five wells may be used. The boundary of the plume may be determined by linear interpolation consistent with the methods described in 135.10(2)*"f"*(3); and

(10) The estimated volume of free product present, how the volume was calculated, recoverable volume and estimated recovery time.

e. The department will review the free product assessment report; and, if approved, the owner or operator must implement the installation of the approved recovery system within 60 days or other time period approved by the department.

f. Termination of free product recovery activities. Owners and operators may propose to the department to terminate free product recovery activities when significant amounts of hydrocarbons are not being recovered. The department will consider proposals to terminate free product recovery when the amount of product collected from a monitoring well is equal to or less than 0.1 gallon each month for a year unless another plan is approved by the department. When free product activities have been terminated, owners and operators must inspect the monitoring wells monthly for at least a year. The department must be notified and free product recovery activities reinitiated if during the monthly well inspections it is determined the product thickness in a monitoring well exceeds 0.02 foot. The monthly well inspection records must be kept available for review by the department.

g. Unless directed to do otherwise by the department, prepare and submit to the department within 180 days after confirming a release, a Tier 2 site cleanup report.

567—135.8(455B) Risk-based corrective action.

135.8(1) *General.* The objective of risk-based corrective action is to effectively evaluate the risks posed by contamination to human health, safety and the environment using a progressively more site-specific, three-tiered approach to site assessment and data analysis. Based on the tiered assessment, a corrective action response is determined sufficient to remove or minimize risks to acceptable levels. Corrective action response includes a broad range of options including reduction of contaminant concentrations through active or passive methods, monitoring of contamination, use of technological controls or institutional controls.

a. Tier 1. The purpose of a Tier 1 assessment is to identify sites which do not pose an unreasonable risk to public health and safety or the environment based on limited site data. The objective is to determine maximum concentrations of chemicals of concern at the source of a release(s) in soil and groundwater. The Tier 1 assessment assumes worst-case scenarios in which actual or potential receptors could be exposed to these chemicals at maximum concentrations through certain soil and groundwater pathways. The point of exposure is assumed to be the source showing maximum concentrations. Risk-based screening levels (Tier 1 levels) contained in the Tier 1 Look-Up Table have been derived from models which use conservative assumptions to predict exposure to actual and potential receptors. (These models and default assumptions are contained in Appendix A.) If Tier 1 levels are not exceeded for a pathway, that pathway may not require further assessment. If the maximum concentrations exceed a Tier 1 level, the options are to conduct a more extensive Tier 2 assessment, apply an institutional control, or in limited circumstances excavate contaminated soil to below Tier 1 levels. If all pathways clear the Tier 1 levels, it is possible for the site to obtain a no action required classification.

b. Tier 2. The purpose of a Tier 2 assessment is to use site-specific data to assess the risk from chemicals of concern to existing receptors and potential receptors using fate and transport models in accordance with 135.10(455B). See 135.10(2)*"a."*

c. Tier 3. Where site conditions may not be adequately addressed by Tier 2 procedures, a Tier 3 assessment may provide more accurate risk assessment. The purpose of Tier 3 is to identify reasonable exposure levels of chemicals of concern and to assess the risk of exposure to existing and potential receptors based on additional site assessment information, probabilistic evaluations, or sophisticated chemical fate and transport models in accordance with 135.11(455B).

d. Notification. Whenever the department requires a tiered site assessment and a public water supply well is within 2,500 feet of a leaking underground storage tank site, the department will notify the public water supply operator.

135.8(2) *Certified groundwater professional.* All assessment, corrective action, data analysis and report development required under rules 135.6(455B) to 135.12(455B) must be conducted by or under the supervision of a certified groundwater professional in accordance with these rules and department guidance as specified.

135.8(3) *Chemicals of concern.* Soil and groundwater samples from releases of petroleum regulated substances must always be analyzed for the presence of benzene, ethylbenzene, toluene, and xylenes. In addition, if the release is suspected to include any petroleum regulated substance other than gasoline or gasoline blends, or if the source of the release is unknown, the samples must be tested for the presence of Total Extractable Hydrocarbons (TEH). Appendices A and B and department Tier 2 guidance define a method for converting TEH values to a default concentration for naphthalene, benzo(a)pyrene, benz(a)anthracene and chrysene and conversion back to a representative TEH value. These default values must be used in order to apply Tier 2 modeling to these constituents in the absence of accurate laboratory analysis. At Tier 2 and Tier 3, owners and operators have the option of analyzing for these specific constituents and applying them to the specific target levels in Appendices A and B instead of using the TEH conversion method if an approved laboratory and laboratory technique are used.

135.8(4) *Boring depth for sampling.* When drilling for the placement of groundwater monitoring wells, if groundwater is encountered, drilling must continue to the maximum of 10 feet below the first encountered groundwater or to the bottom of soil contamination as estimated by field screening. If groundwater is not encountered, drilling must continue to the deeper of 10 feet below the soil contamination as estimated by field screening or 75 feet from the ground surface.

135.8(5) *Bedrock aquifer assessment.* Prior to conducting any groundwater drilling, a groundwater professional must determine if there is a potential to encounter bedrock before groundwater. These potential areas include (1) areas where karst features or outcrops exist in the vicinity and (2) areas with bedrock less than 50 feet from the surface as illustrated in Tier 1 and Tier 2 guidance. The purpose of this determination is to prevent drilling through contaminated subsurface areas thereby creating a preferential pathway to a bedrock aquifer. If the first encountered groundwater is above bedrock but near the bedrock surface or fluctuates above and below bedrock, the groundwater professional should evaluate the subsurface geology and aquifer characteristics to determine the potential for creating a preferential pathway. If it is determined that the aquifer acts like a nongranular aquifer as provided in 135.10(3)*"a"* or bedrock is encountered before groundwater, the groundwater professional must conduct a Tier 2 assessment for all pathways under 135.10(455B), including the specified bedrock procedures under 135.10(3).

If the first encountered groundwater is above bedrock with sufficient separation and aquifer characteristics to establish that it acts as a granular aquifer, site assessment may proceed under the site check procedure in 135.6(455B), the Tier 1 procedure in 135.9(455B) or the Tier 2 procedure in 135.10(455B) as would be customary regardless of the bedrock designation. However, even under this condition, drilling through bedrock should be avoided in contaminated areas.

567—135.9(455B) Tier 1 site assessment policy and procedure.

135.9(1) *General.* The main objective of a Tier 1 site assessment is to reasonably determine the highest concentrations of chemicals of concern which would be associated with any suspected or confirmed release and an accurate identification of applicable receptors. In addition, the placement and depth of borings and the construction of monitoring wells must be sufficient to determine the sources of all releases, the vertical extent of contamination, an accurate description of site stratigraphy, and a reliable determination of groundwater flow direction.

a. Pathway assessment. The pathways to be evaluated at Tier 1 are the groundwater ingestion pathway, soil leaching to groundwater pathway, groundwater vapor to enclosed space pathway, soil vapor to enclosed space pathway, soil to plastic water line pathway, groundwater to plastic water line pathway and the surface water pathway. Assessment requires a determination of whether a pathway is complete, an evaluation of actual and potential receptors, a determination of whether conditions are satisfied for obtaining no further action clearance for individual pathways, or for obtaining a complete site classification of "no action required." A pathway is considered complete if a chemical of concern has a route which could be followed to reach an actual or potential receptor.

b. Pathway clearance. If field data for an individual pathway does not exceed the applicable Tier 1 levels or if a pathway is incomplete, no further action is required to evaluate the pathway unless otherwise specified in these rules. If the field data for a pathway exceeds the applicable Tier 1 level(s) in the "Iowa Tier 1 Look-up Table," the response is to conduct further assessment under Tier 2 or Tier 3 unless an effective institutional control

is approved. In limited circumstances excavation of contaminated soils may be used as an option to obtain pathway clearance. If further site assessment indicates site data exceeds an applicable Tier 1 level(s) for a previously cleared pathway or the conditions justifying a determination of pathway incompleteness change, that pathway must be reevaluated as part of a Tier 2 or Tier 3 assessment.

c. Chemical group clearance. If field data for all chemicals of concern within a designated group of chemicals is below the Tier 1 levels, no further action is required as to the group of chemicals unless otherwise specified in these rules. Group one consists of benzene, ethylbenzene, toluene, and xylenes (BTEX). Group two consists of naphthalene, benzo(a)pyrene, benz(a)anthracene and chrysene; TEH default values are incorporated into the Iowa Tier 1 Look-Up Table and Appendix A for group two chemicals.

d. Site classification. A site can be classified as no action required only after all pathways have met the conditions for pathway clearance as provided in this rule.

e. Groundwater sampling procedure. Groundwater sampling and field screening must be conducted in accordance with department Tier 1 guidance. A minimum of three properly constructed groundwater monitoring wells must be installed, subject to the limitations on maximum drilling depths, for the purpose of identifying maximum concentrations of groundwater contamination, suspected sources of releases, and groundwater flow direction.

(1) Field screening must be used to locate suspected releases and to determine locations with the greatest concentrations of contamination. Field screening is required as per department guidance at each former and current tank basin, each former and current pump island, along the piping, and at any other areas of actual or suspected releases. In placing monitoring wells, the following must be considered: field screening data, available current and historical information regarding the releases, tank and piping layout, site conditions, and drilling data available from sites in the vicinity. At least one well must be placed at each suspected source of release which shall include at a minimum: the pump island with the greatest field screening level, each current and former underground storage tank basin, and if field screening shows greater levels than at the pump islands or tank basins, at other suspected sources of releases. As a general rule, wells should be installed outside of the tank basin through native soils but as close to the tank basin as feasible. A well must be installed in a presumed downgradient direction and within 30 feet of the sample with the greatest field screening level. Three of the wells must be placed in a triangular arrangement to determine groundwater flow direction.

(2) Where the circumstances which prompt a Tier 1 assessment identify a discrete source and cause of a release, and the groundwater professional is able to rule out other suspected sources or contributing sources such as pump islands, piping runs and tank basins, the application of field screening and groundwater well placement may be limited to the known source.

f. Soil sampling procedure. The objective of soil sampling is to identify the maximum concentrations of soil contamination in the vadose and saturated zones and to identify sources of releases. The same principles stated above apply to soil sampling. Soil samples must be taken from borings with the greatest field screening levels even if the boring will not be converted to a monitoring well. At a minimum, soil and groundwater samples must be collected for analysis from all borings which are converted to monitoring wells.

Iowa Tier 1 Look-Up Table

Media	Exposure Pathway	Receptor	Group 1				Group 2: TEH	
			Benzene	Toluene	Ethylbenzene	Xylenes	Diesel*	Waste Oil
Groundwater (ug/L)	Groundwater Ingestion	actual	5	1,000	700	10,000	1,200	400
		potential	290	7,300	3,700	73,000	75,000	40,000
	Groundwater Vapor to Enclosed Space	all	1,540	20,190	46,000	NA	2,200,000	NA
	Groundwater to Plastic Water Line	all	290	7,300	3,700	73,000	75,000	40,000
	Surface Water	all	290	1,000	3,700	73,000	75,000	40,000
Soil (mg/kg)	Soil Leaching to Groundwater	all	0.54	42	15	NA	3,800	NA
	Soil Vapor to Enclosed Space	all	1.16	48	79	NA	47,500	NA
	Soil to Plastic Water Line	all	1.8	120	43	NA	10,500	NA

NA: Not applicable. There are no limits for the chemical for the pathway, because for groundwater pathways the concentration for the designated risk would be greater than the solubility of the pure chemical in water, and for soil pathways the concentration for the designated risk would be greater than the soil concentration if pure chemical were present in the soil.

TEH: Total Extractable Hydrocarbons. The TEH value is based on risks from naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. Refer to Appendix B for further details.

Diesel*. Standards in the Diesel column apply to all low volatile petroleum hydrocarbons except waste oil.

135.9(2) *Conditions requiring Tier 1 site assessment.* Unless owners and operators choose to conduct a Tier 2 assessment, the presence of bedrock requires a Tier 2 assessment as provided in 135.8(5), or these rules otherwise require preparation of a Tier 2 site assessment, a Tier 1 site assessment must be completed in response to release confirmation as provided in rule 135.6(455B), or tank closure investigation under 135.15(455B), or other reliable laboratory analysis which confirms the presence of contamination above the action levels in 135.14(455B).

135.9(3) *Tier 1 assessment report.* Unless directed to do otherwise by the department or the owners or operators choose to prepare a Tier 2 site cleanup report, owners and operators must assemble information about the site and the nature of the release in accordance with the department Tier 1 guidance, including information gained while confirming the release under 135.6(455B), tank closure under 135.15(455B) or completing the initial abatement measures in 135.7(1) and 135.7(2). This information must include, but is not necessarily limited to, the following:

a. Data on the nature and estimated quantity of release.

b. Results of any release investigation and confirmation actions required by subrule 135.6(3).

c. Results of the free product investigations required under 135.7(3)*"a"*(6), to be used by owners and operators to determine whether free product must be recovered under 135.7(5).

d. Chronology of property ownership and underground storage tank ownership, identification of the person(s) having control of, or having responsibility for the daily operation of the underground storage tanks and the operational history of the underground storage tank system. The operational history shall include, but is not limited to, a description of or suspected known subsurface or aboveground releases, past remediation or other corrective action, type of petroleum product stored, recent tank and piping tightness test results, any underground storage tank system repairs, upgrades or replacements and the underground storage tank and piping leak detection method being utilized. The operational history shall confirm that current release detection methods and record keeping comply with the requirements of 135.5(455B), that all release detection records have been reviewed and report any evidence that a release detection standard has been exceeded as provided in 135.5(4) and 135.5(5).

e. Appropriate diagrams of the site and the underground storage tank system and surrounding land use, identifying site boundaries and existing structures and uses such as residential properties, schools, hospitals, child care facilities and a general description of relevant land use restrictions and known future land use.

f. Current proof of financial responsibility as required by 136.19(455B) and 136.20(455B) and the status of coverage for corrective action under any applicable financial assurance mechanism or other financial assistance program.

g. A receptor survey including but not limited to the following: existing buildings, enclosed spaces (basements, crawl spaces, utility vaults, etc.), conduits (gravity drain lines, sanitary and storm sewer mains and service lines), plastic water lines and other utilities within 500 feet of the source. For conduits and enclosed spaces there must be a description of construction material, conduit backfill material, slope of conduit and trenches (include flow direction of sewers), burial depth of utilities or subsurface enclosed spaces, and the relationship to groundwater elevations.

h. An explosive vapor survey of enclosed spaces where there may be the potential for buildup of explosive vapors. The groundwater professional must provide a specific justification for not conducting an explosive vapor survey.

i. A survey of all surface water bodies within 200 feet of the source.

j. A survey of all active, abandoned and plugged groundwater wells within 1,000 feet of the source with a description of construction and present or future use.

k. Accurate and legible site maps showing the location of all groundwater monitoring wells, soil borings, field screening locations and screening values, and monitoring well and soil boring construction logs.

l. A tabulation of all laboratory analytical results for chemicals of concern and copies of the laboratory analytical reports.

m. Results of hydraulic conductivity testing and description of the procedures utilized.

n. A Tier 1 site assessment in accordance with the department's Tier 1 guidance. The Tier 1 report shall be submitted on forms and in a format prescribed by this guidance. The Tier 1 data analysis shall be performed by using computer software developed by the department or by using the computer software's hard-copy version.

135.9(4) *Groundwater ingestion pathway assessment.* The groundwater ingestion pathway addresses the potential for human ingestion of petroleum-regulated substances from existing groundwater wells or potential drinking water wells.

a. Pathway completeness. This pathway is considered complete if: (1) there is a drinking or non-drinking water well within 1,000 feet of the source(s) exhibiting the maximum concentrations of the chemicals of concern; or (2) the first encountered groundwater is a protected groundwater source.

b. Receptor evaluation. A drinking or non-drinking water well within 1,000 feet of the source(s) is an actual receptor. The Tier 1 levels for actual receptors apply to drinking water wells and the Tier 1 levels for potential receptors apply to non-drinking water wells. Potential receptor points of exposure exist if the first encountered groundwater is a protected groundwater source but no actual receptors presently exist within 1,000 feet of the source.

c. Pathway clearance. If the pathway is incomplete, no further action is required for this pathway. If the Tier 1 level for actual or potential receptors is not exceeded, no further action is required for this pathway. Groundwater wells that are actual or potential receptors may be plugged in accordance with 567—Chapter 39 and 567—Chapter 49 and may result in no further action clearance if the groundwater is not a protected groundwater source and the pathway is thereby incomplete.

d. Corrective action response. If maximum concentrations exceed the applicable Tier 1 levels for either actual or potential receptors, a Tier 2 assessment must be conducted unless effective institutional controls are implemented as provided below. Technological controls are not acceptable at Tier 1 for this pathway. Abandonment and plugging of drinking and non-drinking water wells in accordance with 567—Chapters 39 and 49 is an acceptable corrective action response.

e. Use of institutional controls. To apply an effective institutional control, if drinking or non-drinking water wells are present within 1,000 feet of the source, and the applicable Tier 1 level is exceeded, the well(s) for which there is an exceedence must be properly plugged. If the groundwater is a protected groundwater source and the maximum concentrations do not exceed the Tier 1 level for potential receptors but do exceed the Tier 1 level for actual receptors, the owner or operator must provide notification of site conditions on a department form to the department water supply section, or if a county has delegated authority, then the designated county authority responsible for issuing private water supply construction permits or regulating non-public water well construction as provided in 567—Chapters 38 and 49.

If the groundwater is a protected source and the maximum concentrations exceed the Tier 1 level for potential receptors, the owner or operator must (1) implement an institutional control prohibiting the use of the groundwater for installation of drinking and non-drinking water wells within 1,000 feet of the source; and (2) provide notification as provided above. If an effective institutional control is not feasible, a Tier 2 assessment must be performed for this pathway in accordance with rule 135.10(455B).

f. Receptor evaluation for public water supply wells. If a public water supply well is located within 2,500 feet of the underground storage tank source area, a Tier 2 assessment must be completed for this pathway in accordance with 135.10(455B), unless the department agrees with the recommendation of the owner or operator's groundwater professional that it is unlikely the public water supply well is at risk, even without the benefit of soil and groundwater plume definition and a Tier 2 pathway assessment. The groundwater professional may take into account the factors specified in 135.10(11)*"h."*

135.9(5) *Soil leaching to groundwater pathway assessment.* This pathway addresses the potential for soil contamination to leach to groundwater creating a risk of human exposure through the groundwater ingestion pathway.

a. Pathway completeness. If the groundwater ingestion pathway is complete, the soil leaching to groundwater pathway is considered complete.

b. Receptor evaluation. There is a single receptor type for this pathway and one applicable Tier 1 level.

c. Pathway clearance. If the pathway is incomplete or the pathway is complete and the maximum concentrations of chemicals of concern do not exceed the Tier 1 levels, no further action is required for assessment of this pathway.

d. Corrective action response. If the Tier 1 levels are exceeded for this pathway, a Tier 2 assessment must be conducted or alternatively, institutional controls or soil excavation may be undertaken in accordance with 135.9(7)*"h."*

e. Use of institutional controls. Institutional controls must satisfy the conditions applicable to the groundwater ingestion pathway as provided in 135.9(4)*"e."*

135.9(6) *Groundwater vapor to enclosed space pathway assessment.* This pathway addresses the potential for vapors from contaminated groundwater to migrate to enclosed spaces where humans could inhale chemicals of concern at unacceptable levels. This pathway assessment assumes the health-based Tier 1 levels will adequately protect against any associated short- and long-term explosive risks.

a. Pathway completeness. This pathway is always considered complete for purposes of Tier 1 and must be evaluated.

b. Explosive vapor survey. An explosive vapor survey must be conducted in accordance with procedures outlined in the department Tier 1 guidance. If potentially explosive levels are detected, the groundwater professional must notify the owner or operator with instructions to report the condition in accordance with 567—Chapter 131. The owner or operator must begin immediate response and abatement procedures in accordance with 135.7(455B) and 567—Chapter 133.

c. Receptor evaluation. For purposes of Tier 1, there is one receptor type for this pathway and the Tier 1 level applies regardless of the existence of actual or potential receptors.

d. Pathway clearance. No further action is required for this pathway, if the maximum groundwater concentrations do not exceed the Tier 1 levels for this pathway.

e. Corrective action response. If the maximum concentrations exceed the Tier 1 levels for this pathway, a Tier 2 assessment of this pathway must be conducted unless institutional controls are implemented. Technological controls are not acceptable at Tier 1 for this pathway.

f. Use of institutional controls. An institutional control must be effective to prohibit the placement of enclosed space receptors within 500 feet of the source.

135.9(7) *Soil vapor to enclosed space pathway assessment.* This pathway addresses the potential for vapors from contaminated soils to migrate to enclosed spaces where humans could inhale chemicals of concern at unacceptable levels. This pathway assessment assumes health-based screening levels at Tier 1 will adequately protect against short- and long-term explosive risks.

a. Pathway completeness. This pathway is always considered complete for purposes of Tier 1 and must be evaluated.

b. Explosive vapor survey. An explosive vapor survey must be conducted in accordance with procedures outlined in the department Tier 1 guidance. If potentially explosive levels are detected, the groundwater professional must notify the owner or operator with instructions to report the condition in accordance with 567—Chapter 131. The owner or operator must begin immediate response and abatement procedures in accordance with 135.7(455B) and 567—Chapter 133.

c. Receptor evaluation. For purposes of Tier 1, there is one receptor type for this pathway, and the Tier 1 level applies regardless of existing or potential receptors.

d. Pathway clearance. No further action is required for this pathway, if the maximum soil concentrations do not exceed the Tier 1 levels for this pathway. If the Tier 1 levels are exceeded, soil gas measurements may be taken in accordance with the Tier 2 guidance at the area(s) of maximum concentration. Subject to confirmation sampling, if the soil gas measurements do not exceed the target levels in 135.10(7)*"f,"* no further action is required for this pathway. If the Tier 1 level is not exceeded but the soil gas measurement exceeds the target level, further action is required for the pathway.

e. Soil gas samples. To establish that the soil gas measurement is representative of the highest expected levels, a groundwater professional must obtain two soil gas samples taken at least two weeks apart. One of the samples must be taken below the typical frostline depth during a seasonal period of lowest groundwater elevation.

f. Corrective action response. If the maximum concentrations exceed the Tier 1 levels and the soil gas measurements exceed target levels for this pathway, or if no soil gas measurement was taken, a Tier 2 assessment of this pathway must be conducted unless institutional controls are implemented or soil excavation is conducted as provided below. Technological controls are not acceptable at Tier 1 for this pathway.

g. Use of institutional controls. An institutional control must be effective to eliminate the placement of enclosed space receptors within 500 feet of the source.

h. Soil excavation. Excavation of contaminated soils for the purpose of removing soils contaminated above the Tier 1 levels is permissible as an alternative to conducting a Tier 2 assessment. Adequate field screening methods must be used to identify maximum concentrations during excavation. At a minimum, one soil sample must be taken for field screening every 100 square feet of the base and each sidewall. Soil samples must be taken for laboratory analysis at least every 400 square feet of the base and each sidewall of the excavated area to confirm that remaining concentrations are below Tier 1 levels. If the excavation is less than 400 square feet, a minimum of one sample must be analyzed for each sidewall and the base.

135.9(8) *Groundwater to plastic water line pathway assessment.* This pathway addresses the potential for creating a drinking water ingestion risk due to contact with plastic water lines and causing infusion to the drinking water.

a. Pathway completeness and receptor evaluation.

(1) Actual receptors. This pathway is considered complete for an actual receptor if there is an existing plastic water line within 200 feet of the source and the first encountered groundwater is less than 20 feet below ground surface.

(2) Potential receptors. This pathway is considered complete for a potential receptor if the first encountered groundwater is less than 20 feet below ground surface.

b. Pathway clearance. If the pathway is not complete, no further action is required for this pathway. If the pathway is complete and the maximum concentrations of all chemicals of concern do not exceed the Tier 1 levels for this pathway, no further action is required for this pathway.

c. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. Notification of potential plastic water line impacts may be postponed until completion of Tier 2 if a Tier 2 assessment is required.

d. Corrective action response.

(1) For actual receptors, if the Tier 1 levels are exceeded, all plastic water lines within 200 feet must be replaced with nonplastic lines or the plastic lines must be relocated beyond the 200-foot distance. A Tier 2 assessment must be conducted for this pathway if lines are not replaced or relocated.

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway.

135.9(9) *Soil to plastic water line pathway assessment.* This pathway addresses the potential for creating a drinking water ingestion risk due to contact with plastic water lines and infusion into the drinking water.

a. Pathway completeness.

(1) Actual receptors. This pathway is considered complete for an actual receptor if a plastic water line exists within 200 feet of the source.

(2) Potential receptors. This pathway is always considered complete for potential receptors.

b. Pathway clearance. If the pathway is not complete for actual receptors, no further action is required for this pathway. If the pathway is complete for actual receptors and the maximum concentrations of all chemicals of concern do not exceed Tier 1 levels for this pathway, no further action is required. For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

c. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. Notification of potential plastic water line impacts may be postponed until completion of Tier 2 if a Tier 2 assessment is required.

d. Corrective action response. For actual receptors, if the Tier 1 levels are exceeded for this pathway, the plastic water lines may be replaced with nonplastic lines or the plastic lines must be relocated to a distance beyond 200 feet of the source. Excavation of soils to below Tier 1 levels may be undertaken in accordance with 135.9(7)*"h."* If none of these options is implemented, a Tier 2 assessment must be conducted for this pathway.

135.9(10) *Surface water pathway assessment.* This pathway addresses the potential for contaminated groundwater to impact surface water bodies creating risks to human health and aquatic life.

a. Pathway completeness. This pathway is considered complete if a surface water body is present within 200 feet of the source. For purposes of Tier 1, surface water bodies include both general use segments and designated use segments as provided in 567—subrule 61.3(1).

b. Receptor evaluation. The Tier 1 levels for this pathway only apply to designated use segments of surface water bodies as provided in 567—subrules 61.3(1) and 61.3(5). The point of compliance is the source with the highest concentrations of chemicals of concern. General use segments of surface water bodies as provided in 567—paragraph 61.3(1)*"a"* are only subject to the visual inspection criteria.

c. Visual inspection requirements. A visual inspection of all surface water bodies within 200 feet of the source must be conducted to determine if there is evidence of a sheen on the water or there is evidence of petroleum residue along the bank. If a sheen or residue is evident or has been reported to be present, the groundwater professional must make a sufficient investigation to reasonably determine its source. If in the opinion of the groundwater professional, the sheen is not associated with the underground storage tank site, the professional must report and reasonably justify this opinion. If in the opinion of the groundwater professional the sheen is not a petroleum-regulated substance, a sample must be laboratory tested in accordance with 135.16(455B) to confirm it is not a petroleum-regulated substance.

d. Pathway clearance. If the pathway is not complete or it is complete and the maximum concentrations of all chemicals of concern at the point of compliance do not exceed the Tier 1 levels and there is no petroleum sheen or residue attributable to the site, no further action is required for assessment of this pathway.

e. Corrective action response. If a Tier 1 level is exceeded for any chemical of concern for a designated use segment within 200 feet of the source, or the groundwater professional determines the presence of a petroleum-regulated substance sheen or residue, a Tier 2 assessment of this pathway must be conducted.

135.9(11) *Tier 1 submission and review procedures.*

a. Within 90 calendar days of release confirmation or another reasonable period of time determined by the department, owners and operators must submit to the department a Tier 1 report in a format prescribed by the department and in accordance with these rules and the department Tier 1 guidance.

b. If the owner or operator elects to prepare a Tier 2 site cleanup report instead of a Tier 1 assessment, the department must be notified in writing prior to the expiration of the Tier 1 submission deadline. The Tier 2 site cleanup report must be submitted to the department in accordance with rule 135.10(455B) within 180 calendar days of release confirmation or another reasonable period of time determined by the department.

c. Tier 1 report completeness and accuracy. A Tier 1 report is considered to be complete if it contains all the information and data required by this rule and the department Tier 1 guidance. The report is accurate if the information and data is reasonably reliable based first on application of the standards in these rules and department guidance and second, generally accepted industry standards.

d. The certified groundwater professional shall include the following certification with the Tier 1 site assessment report:

I, _____, Groundwater Professional Certification No. _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, 567—Chapter 135 and the Department of Natural Resources Tier 1 guidance. Based on my knowledge of those documents and information I have prepared and reviewed regarding this site, UST Registration No. _____, LUST No._____ I certify that this document is complete and accurate as provided in 567 IAC 135.9(11)*"c"* and meets the applicable requirements of the Tier 1 site assessment.

Signature:

Date:

e. Upon receipt of the Tier 1 report, the department may review it by reliance on the groundwater professional's certification and a summary review for completeness and accuracy or may undertake a more complete review to determine completeness and accuracy and compliance with department rules and guidance. If the Tier 1 report proposes to classify the site "no action required," the department may review the report as provided in 135.9(11)*"g."*

f. If a "no action required" site classification is not proposed, the department must within 60 days approve the Tier 1 report for purposes of completeness or disapprove of the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this time period, the report is deemed to be accepted for purposes of completeness. The department retains the authority to review the report at the time a no action required site classification is proposed.

g. No action required site classification review. The department will review each Tier 1 report which proposes to classify a site as "no action required" to determine whether the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

135.9(12) *Tier 1 site classification and corrective action response.*

a. No action required site classification. At Tier 1, a site is only eligible for a "no action required" classification. To be classified as no action required, each pathway must meet the requirements for pathway

clearance as specified in this rule. If the department determines a no action required site classification is appropriate, a no further action certificate will be issued as provided in 135.12(10).

b. Where an individual pathway or a chemical group meets the requirements for clearance but the site is not entitled to a no action required classification, only those pathways and chemical groups which do not meet the no further action requirements must be evaluated as part of a Tier 2 assessment as provided in rule 135.10(455B).

c. Compliance monitoring and confirmation sampling. Compliance monitoring is not an acceptable corrective action at Tier 1. Except for soil gas sampling under 135.9(7), confirmation sampling to verify a sample does not exceed a Tier 1 level is not required. However, the department retains the authority to require confirmation sampling from existing groundwater monitoring wells if a no action required classification is being proposed at Tier 1 and the department has a reasonable basis to question the representative validity of the samples based on, for example, the seasonal bias of the sampling, evidence of multiple sources of releases, marginal groundwater monitoring well locations and analytical variability.

d. Expedited corrective action. Expedited corrective action is permissible in accordance with 135.12(11).

567—135.10(455B) Tier 2 site assessment policy and procedure.

135.10(1) *General conditions.* A Tier 2 site assessment must be conducted and a site cleanup report submitted for all sites which have not obtained a no action required site classification and for all pathways and chemicals of concern groups that have not obtained no further action clearance as provided in 135.9(455B). If in the course of conducting a Tier 2 assessment, data indicates the conditions for pathway clearance under Tier 1 no longer exist, the pathway shall be further assessed under this rule. The Tier 2 assessment and report must be completed whenever free product is discovered as provided in 135.7(455B). If the owner or operator elects to complete the Tier 2 site assessment without doing a Tier 1 assessment, all the Tier 1 requirements as provided in 135.9(455B) must be met in addition to requirements under this rule.

a. Guidance. The Tier 2 site assessment shall be conducted in accordance with the department's "Tier 2 Site Assessment Guidance" and these rules. The site cleanup report shall be submitted on forms and in a format prescribed by this guidance. The Tier 2 data analysis shall be performed by using computer software developed by the department or by using the computer software's hard-copy version.

b. Classification. At Tier 2, individual pathways may be classified as high risk or low risk or no action required and separate classification criteria may apply to actual and potential receptors for any pathway. A single pathway may have multiple classifications based on actual or potential receptor evaluations. A pathway must meet both the criteria for actual and potential receptors for the pathway to obtain a classification of no action required. Sites may have multiple pathway classifications. For a site to obtain a no action required classification, all pathways must meet the individual pathway criteria for no action required classification.

c. Public right-of-way. As a general rule, public right-of-way will not be considered an area of potential receptor exposure except for potential sanitary sewer evaluation under the soil and groundwater vapor pathways, subrules 135.10(6) and 135.10(7).

135.10(2) *General Tier 2 assessment procedures.*

a. Objectives. The objective of a Tier 2 assessment is to collect site-specific data and with the use of Tier 2 modeling determine what actual or potential receptors could be impacted by chemicals of concern and what concentrations at the source are predicted to achieve protection of these receptors. Both Tier 1 and Tier 2 are based on achieving similar levels of protection of human health, safety and the environment.

b. Groundwater modeling. Tier 2 uses fate and transport models to predict the maximum distance groundwater contamination is expected to move and the distribution of concentrations of chemicals of concern within this area. The model is used for two basic purposes. One, it is used to predict at what levels of concentration contamination would be expected to impact actual and potential receptors. Two, it is used to determine a concentration at the source which if achieved, and after dispersion and degradation, would protect actual and potential receptors at the point of exposure. In predicting the transport of contaminants, the models assume the contaminant plume is at "steady state" such that concentrations throughout the plume have reached a maximum level and are steady or decreasing. The Tier 2 models are only designed to predict transport in a direct line between the source and downgradient to a receptor. In order to more reasonably define a modeled plume in all directions, paragraph *"i"* defines a method of decreasing modeled concentrations as a percentage of their distance in degrees from the downgradient direction.

c. Soil vapor models. The soil vapor models are vertical transport models and do not use modeling to predict soil contaminant transport horizontally to receptors.

d. Soil leaching to groundwater modeling. The soil leaching to groundwater model is a model that predicts the maximum concentrations of chemicals of concern that would be expected in groundwater due to vertical leaching from the area of maximum soil concentrations and then incorporates the groundwater transport models to predict contaminant transport through groundwater pathways.

e. Modeling default parameters. The Tier 2 model formulas and applicable parameters are designated in Appendix B and must be followed unless otherwise specified in these rules. Unless otherwise specified, target levels at a point of exposure may be the Tier 1 level(s) or may be determined using site-specific parameters. The target level at a point of exposure is calculated using the Tier 1 formulas in Appendix A and either site-specific measurements or the default values for those parameters identified as "optional" and "site-specific" in Appendix B.

f. Source width. The source width and source length are variables used in modeling and must be determined by the following criteria and as specified in the department's Tier 2 guidance. The following are not to be used as criteria for defining the extent of the contaminant plumes.

(1) Source width (equals S_w in models) for groundwater transport modeling. The sum of group one chemical (benzene, toluene, ethylbenzene, xylenes or "BTEX") concentrations for each groundwater sample is determined and the location of the sample with the maximum total BTEX is identified. Linear interpolation is used to estimate the area where groundwater concentrations would be expected to exceed 50 percent of the maximum BTEX value, and this area is considered for the source width measurement. The same procedure is used to determine source width for group two chemicals, using TEH in groundwater. The width of the groundwater contamination perpendicular to estimated groundwater flow direction (S_w) is determined, and the larger of either group one or group two chemicals is used in the groundwater transport model.

(2) Source width (S_w) and source length (equals W in models) for soil leaching to groundwater transport modeling. Both the source width perpendicular to the estimated groundwater flow direction (S_w) and the source length parallel to the estimated groundwater flow direction (W) are used in the soil leaching to groundwater model. The sum of BTEX concentrations for each soil sample is determined and the location of the sample with the maximum total BTEX is identified. Concentrations from both the vadose zone and the saturated zone must be considered when determining the maximum. Linear interpolation is used to estimate the area where soil concentrations would be expected to exceed 50 percent of the maximum BTEX value, and this area is considered for the source width and source length measurements. The same procedure is used to determine source width for group 2 chemicals, using TEH in soil. Source width and source length measurements for BTEX in groundwater are also taken following the same linear interpolation criteria in *"f"*(1) above. The source width value used in the model is the greatest of either the soil source width measurements or the groundwater source width measurement. The source length value used in the model is the greatest of either of the soil source length measurements or the groundwater length measurement.

(3) Estimating source width when free product is present. Groundwater from wells with free product must be analyzed for BTEX and the source width and source length are estimated using the criteria in 135.10(2)*"f"*(1) and 135.10(2)*"f"*(2) above. For those sites with approved site cleanup reports and free product present in wells but actual BTEX values are not available, source width and source length may be estimated in accordance with 135.10(2)*"f"*(1) and 135.10(2)*"f"*(2) using the default BTEX values for groundwater in 135.18(4) or estimated by using the area representing half the distance between wells with free product and wells without free product, whichever method is greater.

g. Modeled simulation line. The simulation line represents the predicted maximum extent of groundwater contamination and distribution of contaminant concentrations between the source(s) and actual or potential receptor locations. The model calculates the simulation line using maximum concentrations at the source(s) and predicting the amount of dispersion and degradation. Modeled data in the simulation line are compared with actual field data to verify the predictive validity of the model and to make risk classification decisions.

h. Modeled site-specific target level (SSTL) line. The modeled SSTL line represents acceptable levels of contaminant concentrations at points between and including the source(s) and an applicable point(s) of exposure or other point(s) of compliance (ex. a potential receptor point of exposure). The SSTL line is calculated by assuming an applicable target level concentration at the point(s) of exposure or point(s) of compliance and modeling back to the source to determine the maximum concentrations at the source (SSTL) that must be achieved to meet the target level at the point of exposure or compliance. Comparison of field data to this SSTL line is used to determine a risk classification and determine appropriate corrective action response.

i. Crossgradient and upgradient modeling. In determining the SSTL line and the simulation line in directions other than downgradient, the modeled contaminant concentrations are applied to reduced distances, as specified in the "Tier 2 Guidance." The modeled results are applied to 100 percent of the distance within an angle of 30 degrees on either side of the range of downgradient directions, as specified in Tier 2 guidance. The modeled results are applied to 20 percent of the distance in the upgradient direction and directly proportional distances between these two outer limits. If the groundwater gradient is less than 0.005 or the groundwater contaminant plume shows no definitive direction or shows directional reversals, the modeled concentrations are applied to 100 percent of the distance in all directions from the source. As the downgradient velocity increases, the upgradient modeled distance is reduced to less than 20 percent of the downgradient modeled distance.

j. Plume definition. The purpose of plume definition at Tier 2 is to obtain sufficient data to determine the impact on actual and potential receptors, to determine and confirm the highest levels of contamination, to verify the validity of the models, and to determine groundwater flow direction. The number and location of borings and monitoring wells and the specificity of plume definition will depend on the pathway or pathways being assessed and the actual or potential receptors of concern. Unless otherwise specified, groundwater and soil contamination shall be defined to Tier 1 levels for the applicable pathways. Linear interpolation between two known concentrations must be used to delineate plume extent. Samples with no concentrations detected shall be considered one-half the detection limit for interpolation purposes.

k. Pathway completeness. Unless a pathway has obtained clearance under Tier 1, each pathway must be evaluated at Tier 2. Pathways are generally considered complete (unless otherwise specified) and receptors affected if actual receptors or potential receptor points of exposure exist within the modeled contaminant plume using the modeled simulation line calculated to the applicable target level at a point of exposure. If the actual contaminant plume exceeds the modeled plume, the pathway is complete and must be evaluated if actual or potential points of exposure exist within a distance extending 10 percent beyond the edge of the defined plume.

l. Points of exposure and compliance. For actual receptors, the point(s) of exposure is the receptor. For potential receptors, the potential receptor point(s) of exposure is determined by using actual plume definition or the modeled simulation line to determine all points which exceed the target level(s) for potential receptors. The potential receptor point(s) of exposure is the location(s) closest to the source where a receptor could reasonably exist and which is not subject to an institutional control; for example, the source is the potential receptor point of exposure if not subject to an institutional control or an adjoining property boundary line if that property is not subject to an institutional control. At Tier 2, the point(s) of exposure or potential receptor point(s) of exposure is a point of compliance unless otherwise specified. Other points of compliance are specified by rules and will generally include all points along the SSTL line for purposes of pathway and site classification and corrective action response.

m. Group two chemicals. At Tier 2, chemical-specific values for the four chemicals may be used or the largest of the four TEH default values. (Refer to Appendix B and department Tier 2 guidance for using the TEH conversion method for modeling.) If chemical-specific values are used, the analytical method must be approved by the department prior to its use.

135.10(3) Bedrock assessment.

a. General. As provided in 135.8(5), if bedrock is encountered before groundwater, special assessment procedures under this subrule apply. The Tier 2 assessment procedures apply to the extent they are not inconsistent with this subrule. The objectives of these special procedures are to avoid creating a preferential pathway for contamination through a confining layer to a bedrock aquifer; to avoid creating a preferential pathway to a fractured system, and to determine whether groundwater transport modeling can be used and, if not, what alternative procedures are required. The owner or operator may choose to conduct a Tier 3 assessment under 135.11(455B) as an alternative to proceeding under this subrule. For sites where bedrock is encountered before groundwater, there are three general categories of site conditions which determine the assessment procedures that apply:

(1) Nongranular bedrock. Nongranular bedrock is bedrock which is determined to not act as a granular aquifer as provided in subparagraph (2). Nongranular bedrock generally has some type of fractured system where groundwater transport modeling cannot be applied and which makes it difficult to define the extent of contamination.

(2) Granular bedrock. Granular bedrock is bedrock which is determined to act as a granular aquifer and for which monitoring wells do not exist at the source as of August 15, 1996. For purposes of this rule, a granular aquifer is one that shows no extraordinary variations or inconsistencies in groundwater elevations across the

site, groundwater flow, hydraulic conductivities, or total dissolved solid concentrations among monitoring wells. Although the extent of contamination can be defined in granular bedrock, groundwater transport modeling cannot be used because there are no monitoring wells at the source.

(3) Exempt granular bedrock. Exempt granular bedrock is bedrock which is determined to act as a granular aquifer as provided in subparagraph (2) and for which monitoring wells exist at the source as of August 15, 1996. Sites in exempt granular bedrock shall be evaluated using the normal Tier 1 or Tier 2 procedures in this rule. Nongranular bedrock is not exempt from this subrule even if groundwater monitoring wells exist at the source.

b. Exempt soil pathways. The soil vapor to enclosed space pathway and the soil to plastic water lines pathway shall be assessed under the normal Tier 2 procedures in subrules 135.10(7) and 135.10(9) respectively. In all cases, the normal assessment must comply with the policy of avoiding a preferential pathway to groundwater consistent with 135.8(5) and this subrule.

c. Soil and groundwater assessment. The vertical and horizontal extent of soil contamination shall first be defined to Tier 1 levels for the soil leaching to groundwater pathway without drilling into bedrock. A minimum of three groundwater monitoring wells shall be located and installed between 50 to 100 feet beyond the soil contamination Tier 1 levels to avoid creating a preferential pathway. Analytical data as normally required by these rules and guidance must be obtained.

d. Soil contamination remediation. For all sites where soil contamination exceeds the soil leaching to groundwater Tier 1 levels, soil excavation or other active soil remediation technology must be conducted in accordance with department guidance to reduce concentrations to below this Tier 1 level. Soil remediation monitoring must be conducted in accordance with 135.12(455B).

e. Groundwater plume definition. If it is determined the groundwater acts in a manner consistent with a granular aquifer as provided in subparagraph *"a"*(2) and guidance but does not meet the criteria for exemption under subparagraph *"a"*(3), the plume must be defined. The policy of avoiding the creation of a preferential pathway to the bedrock aquifer in accordance with 135.8(5) must be followed.

f. Soil leaching to groundwater ingestion pathway. Under this subrule, the soil leaching to groundwater pathway only need be evaluated in combination with the groundwater ingestion pathway. Because of the policies requiring soil remediation to the soil leaching to groundwater Tier 1 levels under paragraphs *"d"* and *"k,"* the soil leaching pathway target levels applicable to other groundwater transport pathways and other soil pathways would not be exceeded. If a soil leaching to groundwater Tier 1 level is exceeded, the pathway is high risk.

g. Special procedures for the groundwater ingestion pathway.

(1) A protected groundwater source is assumed without measurements of hydraulic conductivity for all sites designated as granular or nongranular bedrock.

(2) Groundwater well receptor evaluation for granular and nongranular bedrock designations. All drinking and non-drinking water wells within 1,000 feet of the source must be identified and tested for chemicals of concern. All public water supply systems within one mile of the source must be identified and raw water tested for chemicals of concern. If no drinking water wells are located within 1,000 feet of the source, all the area within 1,000 feet is considered a potential receptor point of exposure.

(3) Target levels. The following target levels apply regardless of granular aquifer designation. If drinking water wells are within 1,000 feet of the source, the applicable target level is the groundwater ingestion pathway Tier 1 level for actual receptors. If non-drinking water wells are within 1,000 feet of the source, the applicable target level is the groundwater ingestion pathway Tier 1 level for potential receptors. For potential wells, the applicable target level is the groundwater ingestion pathway Tier 1 level for potential receptors.

(4) Sentry well. If the Tier 1 level for actual receptors is exceeded at sites designated as granular bedrock and the receptor has not yet been impacted, a monitoring well shall be placed between the source and an actual receptor, outside the defined plume and approximately 200 feet from the actual receptor. For alternative well placement, the certified groundwater professional must provide justification and obtain department approval. This monitoring well is to be used for monitoring potential groundwater contamination of the receptor.

(5) High risk classification. A site where bedrock is encountered before groundwater shall be classified high risk for this pathway if any of the following conditions exist regardless of granular aquifer determination: The target level at any actual receptor is exceeded; drinking water well receptors are present within 1,000 feet and groundwater concentrations in any monitoring well exceed the groundwater ingestion Tier 1 level for actual receptors; non-drinking water wells are within 1,000 feet and groundwater concentrations in any monitoring well exceed the groundwater ingestion pathway Tier 1 level for potential receptors; or for sites designated nongranular bedrock, if groundwater concentrations for chemicals of concern from any public water system well within one

mile of the source exceed 40 percent of the Tier 1 level for actual receptors, and groundwater concentrations in any monitoring well exceed the groundwater ingestion Tier 1 level for actual receptors. Corrective action shall be undertaken as provided in paragraph *"k."*

(6) Low risk classification. Sites without an actual receptor within 1,000 feet shall be classified as low risk for this pathway if no high risk conditions exist, and the Tier 1 level for potential receptors is exceeded. The site is subject to monitoring as provided in paragraph *"l."* If an actual receptor exists within 1,000 feet, a site designated as granular or nongranular bedrock shall be classified low risk for this pathway when soil contamination has been removed or remediated to below the soil leaching to groundwater Tier 1 levels, and all groundwater monitoring wells are non-detect or below the applicable target level for actual and potential receptors. A site may be reclassified to no action required for this pathway after all monitoring wells meet the exit monitoring criteria as specified in paragraph *"l."* (NOTE: Exit monitoring is required because groundwater monitoring wells are not located at the source or if they are, the data is highly unreliable given the nature of bedrock.) If actual receptors do not exist or have been properly plugged and concentrations exceed the Tier 1 level for potential receptors, institutional controls and notification to permitting authorities may be employed in accordance with 135.10(4)*"i."* The institutional control must prohibit use of groundwater for 1,000 feet.

h. Special procedures for the groundwater vapor to enclosed space pathway.

(1) Soil gas plume. Soil gas measurements must be taken regardless of granular aquifer determination and in accordance with Tier 2 guidance to determine a soil gas plume. Soil gas where practical should be measured at the soil-bedrock interface. At a minimum, soil gas must be measured at the suspected area of maximum contamination and near the three monitoring wells with the highest concentrations that exceed the Tier 1 level for the groundwater to enclosed space pathway. Where the plume has been defined, soil gas measurements should be taken near wells exceeding the Tier 1 level. Other soil gas measurements must be taken as needed to define the extent of contamination where soil gas measurements exceed the soil gas vapor target levels.

(2) The soil gas target levels are those defined in 135.10(7)*"f."*

(3) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if an actual confined space receptor exists within 50 feet of the soil gas plume based on the soil gas target level as defined in 135.10(6).

(4) Low risk classification. A site designated as granular or nongranular bedrock shall be classified as low risk for this pathway if the soil gas exceeds the vapor target level at any point and no actual confined space receptors exist within 50 feet of the soil gas contaminant plume.

i. Special procedure for the groundwater to plastic water line pathway.

(1) Target level. The applicable target level is the Tier 1 level for plastic water lines.

(2) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if the highest groundwater elevation is higher than three feet below the bottom of a plastic water line as provided in 135.10(8)*"a"*(1), risk classification cannot be determined as provided in 135.12(455B) due to limitations on placement of monitoring wells, and plastic water lines exist within 200 feet of a monitoring well which exceeds the Tier 1 level.

j. Special procedures for the surface water pathway. Any surface water body within 200 feet of the source must be evaluated under the following for sites designated as granular or nongranular bedrock. The provisions of 135.10(10) apply to the extent they are not inconsistent with the following, including the visual inspection requirements.

(1) Point of compliance. The monitoring well closest to the surface water body must be used as the point of compliance to evaluate impacts to designated use segments as described in 135.10(10) and for general use segments that fail the visual inspection criteria of 135.10(10)*"b."* If the surface water criteria is exceeded for a designated use segment, an allowable discharge concentration must be calculated and met at the point of compliance. For general use segments failing the visual inspection criteria, the acutely toxic target level must be met at the point of compliance.

(2) High risk classification. A site designated as granular or nongranular bedrock shall be classified high risk for this pathway if the surface water body is within 200 feet of the source, risk classification cannot be determined as per 135.12(455B) due to limitations on placement of monitoring wells, and the monitoring well closest to the designated use segment exceeds the allowable discharge concentration. A general use segment failing the visual inspection criteria is high risk if, after the sheen is removed, the monitoring well closest to the general use segment exceeds the acutely toxic target level.

(3) Low risk classification. If the allowable discharge concentration is not exceeded at the point of compliance, the site shall be classified as low risk for this pathway and subject to monitoring under paragraph *"l."* The monitoring well closest to the receptor shall serve as the sentry well for monitoring purposes.

k. High risk corrective action response. Owners and operators have the option to conduct a Tier 3 assessment in accordance with 135.11(455B).

(1) Groundwater ingestion pathway. For high risk sites, where soil exceeds the soil leaching to groundwater Tier 1 level for actual receptors, soil excavation or other active remediation of soils must be conducted in accordance with department guidance to reduce soil concentrations below the soil leaching Tier 1 level. Corrective action other than monitoring of groundwater is required at sites designated as nongranular bedrock if the actual receptor has been or is likely to be impacted. Corrective action other than monitoring of groundwater is required at sites designated as granular bedrock if the actual receptor has been impacted or the sentry well required by 135.10(3)*"g"*(4) has been impacted above Tier 1 levels. Acceptable corrective action for impacted or vulnerable groundwater wells may include active remediation, technological controls, institutional controls, well plugging, relocation, and well reinstallation with construction measures sufficient to prevent contaminant infiltration to the well and to prevent formation of a preferential pathway.

(2) Groundwater ingestion pathway high risk monitoring. For high risk sites designated as nongranular or granular bedrock, if the soil concentrations do not exceed the soil leaching to groundwater Tier 1 levels or have been reduced to this level by corrective action, and corrective action of groundwater is not required as in subparagraph (1), these sites shall be subject to groundwater monitoring as provided in paragraph *"l."* Corrective action other than monitoring of groundwater is required at sites designated as granular bedrock if groundwater concentrations exceed the applicable target level less than 200 feet from an actual receptor. Reevaluation of the potential for impact to actual receptors is required at sites designated as nongranular bedrock if concentrations from monitoring wells increases more than 20 percent of the previous samples.

(3) Other pathways. For high risk sites other than groundwater ingestion, active remediation must be conducted to reduce concentrations below the applicable target levels including the use of institutional and technological controls.

l. Monitoring. For high and low risk sites, annual monitoring at a minimum is required as specified below, and potential receptor status for low risk sites must be confirmed. Annual monitoring may be used to meet the exit requirements for no action required classification in accordance with paragraph *"m."*

(1) Groundwater in nongranular bedrock designations. All groundwater monitoring wells must be monitored at least annually.

(2) Groundwater in granular bedrock designations. The following monitoring wells must be monitored at least annually: a well with detected levels of contamination closest to the leading edge of the groundwater plume between the source and the receptor, and a sentry well with concentrations below the applicable target level consistent with subparagraph *"g"*(4) and paragraph *"j."*

(3) Soil gas. For sites where the soil gas target level is exceeded, annual monitoring of soil gas is required at the suspected area of maximum contamination and between the soil gas plume and any actual receptors within 100 feet of the soil gas plume.

m. No action required classification. A site may be given a no action required classification after conducting a Tier 2 assessment as provided in this subrule if maximum soil concentrations do not exceed the Tier 1 levels for the soil leaching pathway, and if groundwater exit monitoring criteria and soil gas confirmation sampling are met as specified below.

(1) Groundwater in nongranular bedrock designations. Exit monitoring requires that samples from all groundwater monitoring wells must not exceed the applicable target levels for annual sampling for three consecutive years.

(2) Groundwater in granular bedrock designations. Exit monitoring must be met in two ways: A monitoring well between the source and the receptor must not exceed applicable target levels for three sampling events, and samples must be separated by at least six months; and the three most recent consecutive groundwater samples from a monitoring well between the source and the receptor with detected levels of contamination must show a steady or declining trend and meet the following criteria: The first of the three samples must be more than detection limits, concentrations cannot increase more than 20 percent from the first of the three samples to the third sample; concentrations cannot increase more than 20 percent of the previous sample; and samples must be separated by at least six months.

(3) Soil gas. Confirmation sampling for soil gas must be conducted as specified in 135.12(6)*"c."*

n. After receiving a no action required classification, all monitoring wells must be properly plugged in accordance with 567—Chapters 39 and 49.

135.10(4) *Groundwater ingestion pathway assessment.*

a. Pathway completeness. Unless cleared at Tier 1, this pathway is complete and must be evaluated under any of the following conditions: (1) the first encountered groundwater is a protected groundwater source; or (2) there is a drinking water well or a non-drinking water well within the modeled groundwater plume or the actual plume as provided in 135.10(2)*"j"* and 135.10(2)*"k."* A public water supply screening and risk assessment must be conducted in accordance with 135.10(4)*"f"* for this pathway.

b. Receptor evaluation. All drinking and non-drinking water wells located within 100 feet of the largest actual plume (defined to the appropriate target level for the receptor type) must be tested, at a minimum, for chemicals of concern as part of the receptor evaluation. Actual plumes refer to groundwater plumes for all chemicals of concern. Untreated or raw water must be collected for analysis unless it is determined to be infeasible or impracticable. The certified groundwater professional or the department may request additional sampling of drinking water wells and non-drinking water wells as part of its evaluation.

All existing drinking water wells and non-drinking water wells within the modeled plume or the actual plume as provided in paragraph *"a"* must be evaluated as actual receptors. Potential receptors only exist if the groundwater is a protected groundwater source. Potential receptor points of exposure are those points within the modeled plume or actual plume that exceed the potential point of exposure target level. The point(s) of compliance for actual receptor(s) is the receptor. The point(s) of compliance for potential receptor(s) is the potential receptor point of exposure as provided in 135.10(2)*"j"* and 135.10(2)*"k."*

c. Target levels. For drinking water wells, the target level at the point(s) of exposure is the Tier 1 level for actual receptors. For non-drinking water wells, the target level at the point(s) of exposure is the Tier 1levels for potential receptors. For potential receptors, the target level at the potential receptor point(s) of exposure is the Tier 1 level for potential receptors.

d. The soil leaching to groundwater pathway must be evaluated in accordance with 135.9(5) if this pathway is complete.

e. Modeling. At Tier 2, the groundwater well located within the modeled plume is assumed to be drawing from the contaminated aquifer, and the groundwater transport model is designed to predict horizontal movement to the well. If the groundwater professional determines that assessment of the vertical movement of contamination is advisable to determine the potential or actual impact to the well source, a Tier 3 assessment of this vertical pathway may be conducted. The groundwater professional shall submit a work plan to the department specifying the assessment methods and objectives for approval in accordance with 135.11(455B). Factors which should be addressed include, but are not limited to, well depth and construction, radius of influence, hydrogeologic separation of aquifer, preferential pathways, and differing water quality characteristics.

f. Public water supply well assessment. The groundwater professional shall identify all public water supply wells located outside the applicable modeled plume but within 2,500 feet of the leaking underground storage tank site. The certified groundwater professional shall conduct a preliminary assessment of the potential risk of impact from the underground storage tank release to the public water supply well based on available information and taking into account the assessment factors in 135.10(11)*"h"* and other relevant considerations. The certified groundwater professional shall submit a public water supply well risk assessment report either prior to or along with the Tier 2 site cleanup report. The risk assessment shall, at a minimum, provide an analysis of the potential risk of impact from the underground storage tank site release to the public water supply well and a recommendation as to whether it is unlikely the underground storage tank release poses an unreasonable risk of impact to the well. If the groundwater professional determines that a professional judgment cannot reasonably be offered without collection of further data, the report shall make a recommendation as to what further data might be developed to assess the risk to the well.

g. Plume definition. The groundwater plume shall be defined to the applicable Tier 1 level for actual receptors except, where there are no actual receptors and the groundwater is a protected groundwater source, the plume shall be defined to the Tier 1 level for potential receptors.

h. Pathway classification. This pathway shall be classified as high risk, low risk or no action required in accordance with 135.12(455B).

i. Corrective action response. Corrective action must be conducted in accordance with 135.12(455B). Abandonment and plugging of wells in accordance with 567—Chapters 39 and 49 is an acceptable corrective action response.

j. Use of institutional controls. The use of institutional controls may be used to obtain no action required pathway classification. If the pathway is complete and the concentrations exceed the applicable Tier 1 level(s) for actual receptors, the drinking or non-drinking water well must be properly plugged in accordance with 567—Chapters 39 and 49 and the institutional control must prohibit the use of a protected groundwater source (if one exists) within the actual or modeled plume as provided in 135.10(2)*"j"* and 135.10(2)*"k."* If the Tier 1 level is exceeded for potential receptors, the institutional control must prohibit the use of a protected groundwater source within the actual or modeled plume, whichever is greater. If concentrations exceed the Tier 1 level for drinking water wells and the groundwater is a protected groundwater source, the owner or operator must provide notification of the site conditions on a department form to the department water supply section, or if a county has delegated authority, then the designated county authority responsible for issuing private water supply construction permits or regulating non-public water well construction as provided in 567—Chapters 38 and 49.

k. Notification of well owners. Upon receipt of a Tier 2 site cleanup report and as soon as practicable, the department shall notify the owner of any public water supply well identified within the Tier 2 site cleanup report that a leaking underground storage tank site is within 2,500 feet and an assessment has been performed.

135.10(5) *Soil leaching to groundwater pathway assessment.*

a. General. The soil leaching to groundwater pathway is evaluated using a one-dimensional model which predicts vertical movement of contamination through soil to groundwater and transported by the groundwater to a receptor. The model is used to predict the maximum concentrations of chemicals of concern that would be present in groundwater beneath a source which is representative of residual soil contamination and maximum soil concentrations. The predicted groundwater concentrations then must be used as a groundwater source concentration to evaluate its impact on other groundwater transport pathways, including the groundwater ingestion pathway, the groundwater vapor pathway, the groundwater plastic line pathway and the surface water pathway.

b. Pathway completeness. This pathway is complete whenever a groundwater transport pathway is complete as provided in this rule.

c. Plume definition. The soil plume shall be defined to the Tier 1 levels for the soil leaching to groundwater pathway.

d. Receptor evaluation. Receptors for this pathway are the same as the receptors for each complete groundwater transport pathway.

e. Modeling and target levels. The soil and groundwater parameters shall be measured as provided in 135.10(2).

The soil leaching to groundwater model shall be used to calculate the predicted groundwater source concentration. Each applicable groundwater transport pathway model shall then be used in accordance with the rules for that pathway to predict potential impact to actual receptors, the location of potential receptor points of exposure and the site-specific target level (SSTL) in groundwater at the source. This SSTL then is used to calculate a SSTL for soil at the source. If the soil concentrations exceed the SSTL for soil, corrective action response shall be evaluated.

f. Corrective action response. If the maximum soil concentration at the source exceeds the SSTL for soil for actual or potential receptors, corrective action must be taken in accordance with 135.12(455B).

135.10(6) *Groundwater vapor to enclosed space pathway assessment.*

a. Pathway completeness. Unless cleared at Tier 1, this pathway is always considered complete for purposes of Tier 2.

b. Explosive vapor survey. If an explosive vapor survey has not been conducted as part of a Tier 1 assessment, an explosive vapor survey of enclosed spaces must be conducted during the Tier 2 assessment in accordance with 135.9(6)*"b"* and procedures outlined in the department's Tier 1 guidance.

c. Confined space receptor evaluation. Actual and potential receptors are evaluated at Tier 2 for this pathway.

(1) Actual receptors. An existing confined space within the modeled groundwater plume or the actual groundwater plume as provided in 135.10(2)*"j"* and 135.10(2)*"k"* is an actual receptor. For the purpose of Tier 2, a confined space is a basement in a building occupied by humans. Buildings constructed with a concrete slab on grade or buildings constructed without a concrete slab, but with a crawl space are not considered confined spaces. Sanitary sewers are considered confined space receptors and preferential pathways if an occupied building exists within 200 feet of where the sewer line crosses over or through actual or modeled groundwater contamination which exceeds the target levels calculated for sewers. The sanitary sewer includes its utility envelope. The point

of exposure is the receptor and points of compliance include the locations where target level measurements may be taken as provided in paragraphs *"f"* and *"g."*

(2) Potential receptors. Potential receptors are confined spaces that do not presently exist but could exist in the future. Areas within the actual groundwater plume perimeter or modeled groundwater plume perimeter are considered potential receptor points of exposure. Potential receptors are evaluated and target levels established based on the current zoning as provided in paragraph *"f."* The potential receptor point of exposure is a point of compliance.

d. Owners and operators may be required to address vapor inhalation hazards in occupied spaces other than confined spaces as defined in these rules when evidence arises which would give the department a reasonable basis to believe vapor hazards are present or may occur.

e. Plume definition.

(1) The soil plume must be defined in accordance with 135.10(2)*"f"* for the purposes of estimating source width and source length used in soil leaching to groundwater and groundwater transport models.

(2) The groundwater plume must be defined to the target levels derived from site-specific data as provided in paragraph *"f."*

f. Target levels. Target levels can be based on groundwater concentrations, soil gas measurements, and indoor vapor measurements as provided below.

(1) For actual receptors and potential receptors, groundwater modeling as provided in 135.10(2) is used to calculate the groundwater concentration target level at the point of exposure. Default residential exposure factors, default residential building parameters, and a target risk of 10^{-4} are used to determine target levels for actual receptors and potential receptor points of exposure in residential areas and areas with no zoning. Default nonresidential exposure factors, default nonresidential building parameters, and a target risk of 10^{-4} are used to determine target levels for actual receptors and potential receptor points of exposure in nonresidential areas. Default values are provided in Appendices A and B.

(2) For actual receptors, the indoor vapor target levels are designated in 135.10(7)*"f."* For actual and potential receptors, the soil gas target levels are designated in 135.10(7)*"f."*

(3) Sanitary sewers are treated as human health receptors, and groundwater concentration target levels at the point of exposure are based on the application of a target risk of 2×10^{-4} for carcinogens and a hazard quotient of 2 for noncarcinogens.

g. Pathway evaluation and classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B).

(1) Actual receptors. If it can be demonstrated that the groundwater plume has reached steady state concentrations under a confined space, indoor vapor measurements at the point(s) of exposure and soil gas measurements at an alternative point(s) of compliance may be used for the pathway evaluation. When assessing sanitary sewers for pathway clearance, soil gas measurements may be evaluated against the soil gas target levels; however, indoor vapor cannot be used as criteria for pathway clearance. Soil gas measurements shall be taken and analyzed in accordance with 135.16(5) and the department's Tier 2 guidance, and at locations in the plume where measured groundwater concentrations exceed the levels which are projected by modeling to exist beneath the actual receptor. If measured groundwater concentrations beneath the actual receptor exceed the levels projected from modeling, then the soil gas measurements may be taken either adjacent to the actual receptor in areas expected to exhibit the greatest soil gas measurements or at an alternative point of compliance between the source and receptor where the actual groundwater concentrations exceed the groundwater concentrations which exist beneath the confined space. If the soil gas measurements and confirmation samples taken in accordance with 135.12(6)*"c"* do not exceed the soil gas target levels, the pathway as to actual receptors shall be classified no action required. If the soil gas target levels are exceeded, either the pathway shall be classified high risk, or indoor vapor measurements may be taken in accordance with the department's Tier 2 guidance. If indoor vapor measurements and confirmation samples do not exceed the indoor vapor target levels, the pathway as to actual confined space receptors shall be classified no action required. If the Tier 1 indoor vapor target levels are exceeded, the pathway shall be classified high risk.

(2) Potential receptors. If the potential receptor groundwater concentration target level(s) is exceeded at any potential receptor point of exposure based on actual data or modeling, the pathway shall be classified low risk. However, if soil gas measurements taken at the potential receptor point(s) of exposure and alternate point(s) of compliance and confirmation samples do not exceed the target levels in 135.10(7)*"f,"* the pathway, as to potential receptors, shall be classified no action required. If the target level(s) for potential sanitary sewer receptors is

exceeded, the pathway shall be classified as low risk. Where the area of potential receptor exposure includes public right-of-way, the pathway may be classified as no action required if the owner or operator provides sufficient documentation to establish that there are no foreseeable plans for construction of sanitary sewers through the area of potential receptor exposure. The municipal authority must acknowledge consent to the no action required classification whenever target levels are exceeded. If the municipal authority reports that it has confirmed plans for construction of sanitary sewers through the area of potential receptor exposure, the pathway shall be reevaluated as an actual receptor.

h. Corrective action response. Unless the pathway is classified as no action required, corrective action for this pathway must be conducted as provided in 135.12(455B). Actual receptors are subject to corrective actions which: (1) reduce groundwater concentrations beneath the enclosed space to below the target level; (2) reduce the measured soil gas levels to below the soil gas target levels; (3) reduce the indoor vapor concentrations to below the indoor vapor target level; or (4) reduce the vapor level to below 10 percent of the lower explosive limit (LEL), if applicable. Potential receptors are subject to the monitoring requirements in 135.12(5). Soil vapor monitoring may be conducted in lieu of groundwater monitoring for this pathway. Institutional or technological controls as provided in 135.12(455B) may be used.

i. Municipal authority notification for potential sewer receptors. The municipal authority responsible for sewer construction must be notified of the environmental conditions whenever target level(s) is exceeded for potential sanitary sewers. The notification must show the area where groundwater concentrations and soil gas samples exceed target levels. The owner or operator must acknowledge what plans, if any, exist for construction of sanitary sewers through the area of potential receptor exposure.

135.10(7) *Soil vapor to enclosed space pathway assessment.*

a. Pathway completeness. Unless cleared at Tier 1, this pathway is always considered complete for purposes of Tier 2.

b. Explosive vapor survey. If an explosive vapor survey has not been conducted as part of a Tier 1 assessment, an explosive vapor survey of enclosed spaces must be conducted during the Tier 2 assessment in accordance with 135.9(6)*"b"* and procedures outlined in the department's Tier 1 guidance.

c. Confined space receptor evaluation. Actual and potential receptors are evaluated at Tier 2 for this pathway.

(1) Actual receptors. An existing confined space within 50 feet of the edge of the plume is an actual receptor. For the purpose of Tier 2, a confined space is a basement in a building occupied by humans. Buildings constructed with a concrete slab on grade or buildings constructed without a concrete slab, but with a crawl space are not considered receptors. Sanitary sewers are considered confined space receptors and preferential pathways if an occupied building exists within 200 feet of where the sewer line crosses over or through soil contamination which exceeds the target levels calculated for sewers. The sanitary sewer includes its utility envelope. The point of exposure is the receptor and points of compliance include the locations where target level measurements may be taken as provided in paragraphs *"f"* and *"g."*

(2) Potential receptors. Potential receptors are confined spaces that do not presently exist but could exist in the future. Areas where soil concentrations are greater than the Tier 1 level applicable to residential areas or alternative target levels for nonresidential areas as specified in paragraph *"f"* are considered potential receptor points of exposure. Potential receptors are evaluated and target levels established based on the current zoning. An area with no zoning is considered residential. The potential receptor point of exposure is a point of compliance.

d. Owners and operators may be required to address vapor inhalation hazards in occupied spaces other than confined spaces as defined in these rules when evidence arises which would give the department a reasonable basis to believe vapor hazards are present or may occur.

e. Plume definition. The soil plume must be defined to the Tier 1 level for this pathway unless vapor measurements taken at the area(s) with the maximum levels of soil contamination do not exceed the soil gas target level in 135.10(7)*"f."* If soil gas measurements taken from the area(s) of maximum soil concentration do not exceed target levels, confirmation sampling must be conducted in accordance with 135.12(6)*"c"* prior to proposing a no action pathway classification.

f. Target levels. Target levels can be based on soil concentrations, soil gas measurements, and indoor vapor measurements as provided below:

(1) For actual receptors, the soil concentration target level is the Tier 1 level. For potential receptors, the soil concentration target level for residential areas and areas with no zoning is the Tier 1 level. For areas

zoned nonresidential, the target level is calculated using the default nonresidential exposure factors and building parameters from Appendix A and a target risk of 10^{-4} .

(2) The following indoor vapor target levels apply to actual receptors other than sanitary sewers and the soil gas target levels apply to all actual and potential receptors. These levels were derived from the ASTM indoor air inhalation and the soil vapor to enclosed space models designated in Appendix A.

	Indoor Vapor ($\mu g/m^3_{air}$)	**Soil Gas ($\mu g/m^3$)**
Benzene	39.2	600,000
Toluene	555	9,250,000

(3) Sanitary sewers are treated as human health receptors, and soil concentration target levels at the point of exposure are based on application of a target risk of 2 x 10^{-4} for carcinogens and hazard quotient of 2 for noncarcinogens.

g. Pathway evaluation and classification.

(1) Actual receptors. Confined space receptors may be evaluated using soil gas measurements and indoor vapor measurements. When assessing sanitary sewers for pathway clearance, soil gas measurements may be evaluated against the soil gas target levels, however, indoor vapor cannot be used as criteria for pathway clearance. Soil gas measurements shall be taken adjacent to the actual receptor or at an alternative point of compliance between the source and receptor such as the property boundary, and in accordance with 135.16(5) and the department's Tier 2 guidance. If the soil gas measurements and confirmation samples taken in accordance with 135.12(6)*"c"* do not exceed the soil gas target levels, the pathway as to actual receptors shall be classified no action required. If the soil gas target levels are exceeded, either the pathway shall be classified high risk, or indoor vapor measurements may be taken in accordance with the department's Tier 2 guidance. If indoor vapor measurements and confirmation samples do not exceed the indoor vapor target levels, the pathway as to actual receptors shall be classified no action required. If the indoor vapor target levels are exceeded, the pathway shall be classified high risk.

(2) Potential receptors. If the potential receptor target level(s) based on soil concentrations is exceeded at any potential receptor point of exposure, the pathway shall be classified low risk. However, if soil gas measurements taken at the potential receptor point(s) of exposure and alternate point(s) of compliance and confirmation samples do not exceed the target levels in paragraph *"f,"* the pathway shall be classified no action required as to potential receptors. If the target level(s) for potential sanitary sewer receptors is exceeded, the pathway shall be classified as low risk. Where the area of potential receptor exposure includes public right-of-way, the pathway may be classified as no action required if the owner or operator provides sufficient documentation to establish that there are no foreseeable plans for construction of sanitary sewers through the area of potential receptor exposure. The municipal authority must acknowledge consent to the no action required classification whenever target levels are exceeded. If the municipal authority reports that it has confirmed plans for construction of sanitary sewers through the area of potential receptor exposure, the pathway shall be reevaluated as an actual receptor.

h. Corrective action response. Unless the pathway is classified as no action required, corrective action for this pathway must be conducted as provided in 135.12(455B) and in accordance with department Tier 2 guidance. Actual receptors are subject to corrective actions which: (1) reduce the indoor vapor concentrations to below the target level; (2) reduce measured soil gas levels to below the soil gas target levels; and (3) if applicable, reduce the vapor level to below 10 percent of the lower explosive limit (LEL). Potential receptors are subject to monitoring requirements as provided in 135.12(5). Soil vapor monitoring may be conducted in lieu of soil monitoring for this pathway. Institutional or technological controls as provided in 135.12(455B) may be used.

i. Municipal authority notification for potential sewer receptors. The municipal authority responsible for sewer construction must be notified of the environmental conditions whenever target level(s) is exceeded for potential sanitary sewers. The notification must show the area where soil concentrations and soil gas samples exceed target levels. The owner or operator must acknowledge what plans, if any, exist for construction of sanitary sewers through the area of potential receptor exposure.

135.10(8) *Groundwater to plastic water line pathway assessment.*

a. Pathway completeness and receptor evaluation.

(1) Actual receptors include all plastic water lines where the highest groundwater elevation is higher than three feet below the bottom of the plastic line at the measured or predicted points of exposure. The highest groundwater elevation is the estimated average of the highest measured groundwater elevations for each year. All plastic water lines must be evaluated for this pathway regardless of distance from the source and regardless of the Tier 1 evaluation, if the lines are in areas with modeled data above the SSTL line. If actual data exceeds modeled data, then all plastic water lines are considered actual receptors if they are within a distance extending 10 percent beyond the edge of the contaminant plume defined by the actual data.

(2) Potential receptors include all areas where the first encountered groundwater is less than 20 feet deep and where actual data or modeled data are above Tier 1 levels.

(3) The point(s) of exposure is the plastic water line, and the points of compliance are monitoring wells between the source and the plastic water line which would be effective in monitoring whether the line has been or may be impacted by chemicals of concern.

b. Plume definition. If this pathway is complete for an actual receptor, the groundwater plume must be defined to the Tier 1 levels, with an emphasis between the source and any actual plastic water lines. The water inside the plastic water lines shall be analyzed for all chemicals of concern.

c. Target levels. Groundwater modeling as provided in 135.10(2) must be used to calculate the projected concentrations of chemicals of concern and site-specific target levels. The soil leaching to groundwater pathway must be evaluated to ensure contaminated soil will not cause future groundwater concentrations to exceed site-specific target levels. The target level at the point(s) of exposure is the Tier 1 level.

d. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B). The water quality inside the plastic water lines is not a criteria for clearance of this pathway.

e. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. If the extent of contamination has been defined, this information must be included in utility company notification, and any previous notification made at Tier 1 must be amended to include this information.

f. Corrective action response.

(1) For actual receptors, unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B). If the concentrations of chemicals of concern in a water line exceed the Tier 1 levels for actual receptors for the groundwater ingestion pathway, immediate corrective action must be conducted to eliminate exposure to the water, including but not limited to replacement of the line with an approved nonplastic material.

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

135.10(9) *Soil to plastic water line pathway assessment.*

a. Pathway completeness and receptor evaluation.

(1) Actual receptors include all plastic water lines within ten feet of the soil plume defined to the Tier 1 level. All plastic water lines must be evaluated for this pathway regardless of distance from the source, if the lines are in areas where Tier 1 levels are exceeded.

(2) Potential receptors include all areas where Tier 1 levels are exceeded.

b. Plume definition. The extent of soil contamination must be defined to Tier 1 levels for the chemicals of concern.

c. Target level. The point(s) of exposure include all areas within ten feet of the plastic water line. The target level at the point(s) of exposure is the Tier 1 level.

d. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B). Measurements of water quality inside the plastic water lines may be required, but are not allowed as criteria to clear this pathway.

e. Utility company notification. The utility company which supplies water service to the area must be notified of all actual and potential plastic water line impacts. If the extent of contamination has been defined, this information must be included in utility company notification, and any previous notification made at Tier 1 must be amended to include this information.

f. Corrective action response.

(1) For actual receptors, unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B).

(2) For potential receptors, upon utility company notification, no further action will be required for this pathway for potential receptors.

135.10(10) *Surface water pathway assessment.*

a. Pathway completeness. Unless maximum concentrations are less than the applicable Tier 1 levels, this pathway is complete and must be evaluated under any of the following conditions: (1) there is a designated use surface water within the modeled groundwater plume or the actual plume as provided in 135.10(2)*"f"* and 135.10(2)*"g"*; or (2) any surface water body which failed the Tier 1 visual inspection as provided in 135.9(10).

b. Visual inspection. A visual inspection must be conducted according to 135.9(10)*"c."* If a sheen or residue from a petroleum-regulated substance is present, soil and groundwater sampling must be conducted to identify the source of the release and to define the extent of the contaminant plume to the levels acutely toxic to aquatic life as provided in 567—subrule 61.3(2).

c. Receptor evaluation.

(1) Surface water criteria apply only to designated use segments of surface water bodies as provided in 567—subrules 61.3(1) and 61.3(5). If the surface water body is a designated use segment and if maximum groundwater concentrations exceed applicable surface water criteria, the extent of contamination must be defined as provided in paragraph *"d."* The point of compliance for measuring chemicals of concern at the point of exposure is the groundwater adjacent to the surface water body because surface water must be protected for low flow conditions. In-stream measurements of concentrations are not allowed as a basis for no further action.

(2) If the visual inspection indicates the presence of a petroleum sheen in a general use segment within 200 feet of the source, as defined in 567—paragraph 61.3(1)*"a,"* the segment must be evaluated as an actual receptor. The point of compliance for measuring chemicals of concern at the point of exposure is the groundwater adjacent to the general use segment.

d. Plume definition. The groundwater plume must be defined to the surface water criteria levels for designated use segment receptors and to the acutely toxic levels for general use segment receptors, with an emphasis between the source and the surface water body.

e. Target levels. Determining target levels for this pathway involves a two-step process.

(1) Groundwater modeling as provided in 135.10(2) must be used to calculate the projected concentrations of chemicals of concern at the point of compliance. If the modeled concentrations or field data at the point of compliance exceed surface water criteria for designated use segments, an allowable discharge concentration must be calculated. If the projected concentrations and field data at the point of compliance do not exceed surface water criteria, no further action is required to assess this pathway.

(2) The department water quality section will calculate the allowable discharge concentration using information provided by the certified groundwater professional on a department form. Required information includes, at a minimum, the site location and a discharge flow rate calculated according to the department's Tier 2 guidance. The allowable discharge concentration is the target level which must be met adjacent to the surface water body which is the point of compliance.

(3) The target level at the point of exposure/compliance for general use segments subject to evaluation is the acutely toxic levels established by the department under 567—Chapter 61 and 567—subrule 62.8(2). If the modeled concentrations of field data at the point of exposure/compliance exceed the acutely toxic levels, modeling must be used to determine site classifications and corrective action in accordance with 135.12(455B).

f. Pathway classification. Upon completion of analysis of field data and modeled data, the pathway must be classified high risk, low risk or no further action as provided in 135.12(455B).

(1) For general use segments, as defined in 567—subrule 61.3(1), if the groundwater professional determines there is no sheen or residue present or if the site is not the source of the sheen or residue or if the sheen does not consist of petroleum-regulated substances, no further action is required for assessment of this pathway. If a petroleum-regulated substance sheen is present, the pathway is high risk and subject to classification in accordance with 135.12(455B).

(2) For designated use segments, as provided in 567—subrules 61.3(1) and 61.3(5), if projected concentrations of chemicals of concern and field data at the point of compliance do not exceed the target level adjacent to the surface water, and the groundwater professional determines there is no sheen or residue present, no further action is required for assessment of this pathway.

g. Corrective action response. Unless the pathway is classified as no further action, corrective action for this pathway must be conducted as provided in 135.12(455B). For surface water bodies failing the visual inspection

criteria, corrective action must eliminate the sheen and reduce concentrations to below the site specific target level in accordance with 135.12(455B).

135.10(11) *Tier 2 submission and review procedures.*

a. Owners and operators must submit a Tier 2 site cleanup report within 180 days of the date the department approves or is deemed to approve a Tier 1 assessment report under 135.9(12). If the owner or operator has elected to conduct a Tier 2 assessment instead of a Tier 1, or a Tier 2 assessment is required due to the presence of free product under 135.7(5), the Tier 2 site cleanup report must be submitted within 180 days of the date the release was confirmed. The department may establish an alternative schedule for submittal.

b. Site cleanup report completeness and accuracy. A Tier 2 site cleanup report is considered to be complete if it contains all the information and data required by this rule and the department's Tier 2 guidance. The report is considered accurate if the information and data are reasonably reliable based first on the standards in these rules and department guidance, and second, on generally accepted industry standards.

c. The certified groundwater professional responsible for completion of the Tier 2 site assessment and preparation of the report must accompany each Tier 2 site cleanup report with a certification as set out below:

I, _____, groundwater professional certification number _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, the Department of Natural Resources' Tier 2 guidance. Based on my knowledge of those documents and the information I have prepared and reviewed regarding this site, UST registration number _____, LUST No._____, I certify that this document is complete and accurate as provided in 135.10(11) and meets the applicable requirements of the Tier 2 site cleanup report.

Signature

Date

d. Review. Unless the report proposes to classify the site as no action required, the department must approve the report within 60 days for purposes of completeness or disapprove the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this 60-day period, the report is deemed to be approved for purposes of completeness. The department retains the authority to review the report at any time a no action required site classification is proposed.

e. No action required site classification review. The department will review each Tier 2 site cleanup report which proposes to classify a site as no action required to determine the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

f. Upon approval of the Tier 2 site cleanup report or as directed by the department, owners and operators must either implement the corrective action recommendations, including any modifications required by the department, or prepare a Tier 3 site analysis. Owners and operators must monitor, evaluate, and report the results of corrective action activities in accordance with the schedule and on a form or in a format required by the department.

g. The department may, in the interest of minimizing environmental or public health risks and promoting a more effective cleanup, require owners and operators to begin cleanup of soil and groundwater before the Tier 2 site cleanup report is approved.

h. Review of the public water supply receptor risk assessment. The department shall review the public water supply well risk assessment report submitted pursuant to135.10(4) independently or as part of its review of the Tier 2 site cleanup report. Factors which the department may consider when reviewing the risk assessment report include, but are not limited to:

(1) The location of the underground storage tank site within a sensitive area as defined in 135.2(455B) for any identified public water supply well and if so, the potential risk of impact to the well taking into account the well's capture zone and the aquifer susceptibility designation.

(2) Reports of petroleum constituents in the raw or finished water samples from the public water supply well.

(3) Whether corrective action may be required or has been completed for other receptors or pathways which could prevent impact to the public water supply well.

(4) Test results showing the presence or absence of detectable levels of petroleum constituents in a public water supply well, and to what extent the underground storage tank site release or other facilities in the area may be a source or contributing source.

(5) The presence of elevated concentrations of chemicals of concern in the soil or groundwater relative to the distance to the public water supply well and groundwater fate and transport data from other contaminated sources in the vicinity.

(6) Available information on the pumping capacity of the public water supply well and related zone of capture.

(7) Detections of chemicals in water samples tending to establish that the integrity of the well has been compromised or that there is a connection between the contaminated aquifer and the well's source water aquifer.

(8) Available information, including hydrogeological data from other sources in the vicinity, as to the nature and extent of any confining layer between the public water supply well aquifer and the contaminated aquifer.

(9) Information supplied from the public water supply well operator including but not limited to well construction, age, integrity, and pumping capacity.

(10) Water quality data and detections of chemicals tending to establish that the integrity of the well has been compromised or that there is a connection between the contaminated aquifer and the public water supply well.

(11) The distance between the leaking underground storage tank site and the public water supply well.

(12) The age of the release.

(13) Alternative modeling including, but not limited to, mass flux modeling.

If the department concurs with the certified groundwater professional's risk analysis and recommendation that it is unlikely the underground storage tank site release poses an unreasonable risk of impact to the public water supply well, the department may classify the well as no action required.

If after taking into account the groundwater professional's risk analysis, professional recommendations and other relevant data, the department does not accept the certified groundwater professional's recommendations, the department must demonstrate that there is a hydrogeological connection between the underground storage tank contaminated aquifer and the public water supply well and that the underground storage tank release more likely than not poses an unreasonable risk of impact to the public water supply well. If the department establishes this level of proof, it may disapprove the assessment report and require the owner and operator through their certified groundwater professional to submit a Tier 3 work plan. The work plan shall propose what further assessment methods and data would be sufficient to confirm the nature and extent of any risk of impact to the public water supply well from the underground storage tank site release. As an alternative to submitting a Tier 3 work plan for this receptor, owners or operators may participate in a corrective action meeting process to develop a Tier 3 work plan or other corrective action plan, which would be incorporated into a memorandum of agreement or other written agreement approved by the department.

567—135.11(455B) Tier 3 site assessment policy and procedure.

135.11(1) *General.* Tier 3 site assessment. Unless specifically limited by rule or an imminent hazard exists, an owner or operator may choose to prepare a Tier 3 site assessment as an alternative to completion of a Tier 2 assessment under 135.10(455B) or as an alternative to completion of a corrective action design report under 135.12(455B). Prior to conducting a Tier 3 site assessment, a groundwater professional must submit a work plan to the department for approval. The work plan must contain an evaluation of the specific site conditions which justify the use of a Tier 3 assessment, an outline of the proposed Tier 3 assessment procedures and reporting format and a method for determining a risk classification consistent with the policies underlying the risk classification system in 135.12(455B). Upon approval, the groundwater professional may implement the assessment plan and submit a report within a reasonable time designated by the department.

135.11(2) *Tier 3 site assessment.* A Tier 3 assessment may include but is not limited to the use of more site-specific or multidimensional models and assessment data, methods for calibrating Tier 2 models to make them more predictive of actual site conditions, and more extensive assessment of receptor construction and vulnerability to contaminant impacts. If use of Tier 2 models is proposed with substitution of other site-specific data (as opposed to the Tier 2 default parameters), the groundwater professional must adequately justify how site-specific data is to be measured and why it is necessary. The groundwater professional must demonstrate that the proposal has a proven applicability to underground storage tank sites or similar conditions or has a strong theoretical basis for applicability and is not biased toward underestimating assessment results. The Tier 3 assessment report shall make a recommendation for site classification as high risk, low risk or no action required, at least two corrective action response technologies and provide justification consistent with the standards and policies underlying risk classification and corrective action response under 135.12(455B) and Iowa Code chapter 455B, Division 4, Part 8.

135.11(3) *Review and submittal.* The department will review the Tier 3 assessment for compliance with the terms of the approved work plan and based on principles consistent with these rules and Iowa Code chapter 455B, Division IV, Part 8. Upon approval of the Tier 3 assessment, the department may require corrective action in accordance with 135.12(455B).

567—135.12(455B) Tier 2 and 3 site classification and corrective action response.

135.12(1) *General.* 1995 Iowa Code section 455B.474(1)*"d"*(2) provides that sites shall be classified as high risk, low risk and no action required. Risk classification is accomplished by comparing actual field data to the concentrations that are predicted by the use of models. Field data must be compared to the simulation model which uses the maximum concentrations at a source and predicts at what levels actual or potential receptors could be impacted in the future. Field data must also be compared to the site-specific target level line which assumes a target level concentration at the point of exposure and is used to predict the reduction in concentration that must be achieved at the source in order to meet the applicable target level at the point of exposure. These models not only predict concentrations at points of exposure or a point of compliance at a source but also predict a distribution of concentrations between the source and the point of exposure which may also be points of compliance. The comparison of field data with these distribution curves primarily is considered for purposes of judging whether the modeled data is reasonably predictive and what measures such as monitoring are prudent to determine the reliability of modeled data and actual field data.

For the soil vapor to enclosed pathway and soil to plastic water line pathways, there are no horizontal transport models to use predicting future impacts. Therefore, for these pathways, sites are classified as high risk, low risk or no action based on specified criteria below and in 135.10(455B).

135.12(2) *High risk classification.* Except as provided below, sites shall be classified as high risk if, for any pathway, any actual field data exceeds the site-specific target level line at any point for an actual receptor.

a. For the soil vapor to enclosed space and soil to plastic water line pathways, sites shall be classified as high risk if the target levels for actual receptors are exceeded as provided in 135.10(7) and 135.10(9).

b. For the soil vapor or groundwater vapor to enclosed space pathways, sites shall be classified as high risk if the explosivity levels at applicable points of compliance are exceeded as provided in 135.10(6) and 135.10(7).

c. Generally, sites are classified as low risk if only potential receptor points of compliance are exceeded. The following is an exception. For the soil leaching to groundwater ingestion pathway for potential receptor conditions, the site shall be classified as high risk if the groundwater concentration(s) exceeds the groundwater Tier 1 level for potential receptor and the soil concentration exceeds the soil leaching site-specific target level at the source.

135.12(3) *High risk corrective action response.*

a. Objectives. The primary objectives of corrective action in response to a high risk classification are both short- term and long-term. The short-term goal is to eliminate or reduce the risk of exposure at actual receptors which have been or are imminently threatened with exposure above target levels. The longer term goal is to prevent exposure to actual receptors which are not currently impacted or are not imminently threatened with exposure. To achieve these objectives, it is the intent of these rules that concentrations of applicable chemicals of concern be reduced by active remediation to levels below the site-specific target level line at all points between the source(s) and the point(s) of exposure as well as to undertake such interim corrective action as necessary to eliminate or prevent exposure until concentrations below the SSTL line are achieved. If it is shown that concentrations at all applicable points have been reduced to below the SSTL line, the secondary objective is to establish that the field data can be reasonably relied upon to predict future conditions at points of exposure rather than reliance on the modeled data. Reliance on field data is achieved by establishing through monitoring that concentrations within the contaminant plume are steady or declining. Use of institutional control and technological controls may be used to sever pathways or control the risk of receptor impacts.

b. For the soil vapor and soil to plastic water line, these objectives are achieved by active remediation of soil contamination below the target level at the point(s) of exposure or other designated point(s) of compliance using the same measurement methods for receptor evaluation under 135.10(7) and 135.10(9).

c. For a site classified as high risk or reclassified as high risk for the soil leaching to groundwater ingestion pathway, these objectives are achieved by active remediation of soil contamination to reduce the soil concentration to below the site-specific target level at the source.

d. A corrective action design report (CADR) must be submitted by a certified groundwater professional for all high risk sites unless the terms of a corrective action plan are formalized in a memorandum of agreement

within a reasonable time frame specified by the department. The CADR must be submitted on a form provided by the department and in accordance with department CADR guidance within 60 days of site classification approval as provided in 135.10(11). The CADR must identify at least two principally applicable corrective action options designed to meet the objectives in 135.12(3), an outline of the projected timetable and critical performance benchmarks, and a specific monitoring proposal designed to verify its effectiveness and must provide sufficient supporting documentation consistent with industry standards that the technology is effective to accomplish site-specific objectives. The CADR must contain an analysis of its cost-effectiveness in relation to other options. The department will review the CADR in accordance with 135.12(9).

e. Interim monitoring. From the time a Tier 2 site cleanup report is submitted and until the department determines a site is classified as no action required, interim monitoring is required at least annually for all sites classified as high risk. Groundwater samples must be taken: (1) from a monitoring well at the maximum source concentration; (2) from a transition well, meaning a monitoring well with detected levels of contamination closest to the leading edge of the groundwater plume as defined to the pathway-specific target level, and between the source(s) and the point(s) of exposure; and (3) from a guard well, meaning a monitoring well between the source(s) and the point(s) of exposure with concentrations below the SSTL line. If a receptor is located within an actual plume contoured to the applicable target level for that receptor, the point of exposure must be monitored. If concentrations at the receptor already exceed the applicable target level for that receptor, corrective actions must be implemented as soon as practicable. Monitoring conducted as part of remediation or as a condition of establishing a no action required classification may be used to the extent it meets these criteria. Soil monitoring is required at least annually for all applicable pathways in accordance with 135.12(5)*"d."* All drinking water wells and non-drinking water wells within 100 feet of the largest actual plume (defined to the appropriate target level for the receptor type) must be tested annually for chemicals of concern. Actual plumes refer to groundwater plumes for all chemicals of concern.

f. Remediation monitoring. Remediation monitoring during operation of a remediation system is required at least four times each year to evaluate effectiveness of the system. A remediation monitoring schedule and plan must be specified in the corrective action design report and approved by the department.

g. Technological controls. The purpose of a technological control is to effectively sever a pathway by use of technologies such that an applicable receptor could not be exposed to chemicals of concern above an applicable target risk level. Technological controls are an acceptable corrective action response either alone or in combination with other remediation systems. The purpose of technological controls may be to control plume migration through use of containment technologies, barriers, etc., both as an interim or permanent corrective action response or to permanently sever a pathway to a receptor. Controls may also be appropriate to treat or control contamination at the point of exposure. Any technological control proposed as a permanent corrective action option without meeting the reduction in contaminant concentrations objectives must establish that the pathway to a receptor will be permanently severed or controlled. The effectiveness of a technological control must be monitored under a department approved plan until concentrations fall below the site-specific target level line or its effectiveness as a permanent response is established, and no adverse effects are created.

h. Following completion of corrective action, the site must meet exit monitoring criteria to be reclassified as no action required as specified in 135.12(6)*"b."* At any point where an institutional or technological control is implemented and approved by the department, the site may be reclassified as no action required consistent with 135.12(6).

135.12(4) *Low risk classification.* A site shall be classified as low risk if none of the pathways are high risk and if any of the pathways are low risk. A pathway shall be classified low risk if it meets one of the following conditions:

a. For actual and potential receptors, if the modeled data and the actual field data are less than the site-specific target level line, and any of the field data is greater than the simulation line.

b. For potential receptors, if any actual field data exceeds the site-specific target level line at any point.

c. For the soil leaching to groundwater ingestion pathway where modeling predicts that the Tier 1 levels for potential receptors would be exceeded in groundwater at applicable potential receptor points of compliance and the soil concentration exceeds the soil leaching to groundwater site-specific target level but groundwater concentrations are currently below the Tier 1 level for potential receptors, the site shall be initially classified as low risk and subject to monitoring under 135.12(5)*"d"*(2). If at any time during the three-year monitoring period, groundwater concentrations exceed the Tier 1 level for potential receptors, the site shall be classified as high risk requiring soil remediation in accordance with 135.12(3)*"c."*

135.12(5) *Low risk corrective action response.*

a. Purpose. For sites or pathways classified as low risk, the purpose of monitoring is to determine if concentrations are decreasing such that reclassification to no action required may be appropriate or if concentrations are increasing above the site-specific target level line such that reclassification to high risk is appropriate. Monitoring is necessary to evaluate impacts to actual receptors and assess the continued status of potential receptor conditions. Low risk monitoring shall be conducted and reported by a certified groundwater professional.

b. For sites or pathways classified as low risk, provide a best management practices plan. The plan must include maintenance procedures, schedule of activities, prohibition of practices, and other management practices, or a combination thereof, which, after problem assessment, are determined to be the most effective means of monitoring and preventing additional contamination of the groundwater and soil. The plan will also contain a contamination monitoring proposal containing sufficient sampling points to ensure the detection of any significant movement of or increase in contaminant concentration.

c. Groundwater monitoring. For groundwater pathways, samples must be taken at a minimum of once per year: (1) from a monitoring well at the maximum source concentration; (2) a transitional well meaning a well with detected levels of contamination closest to the leading edge of the groundwater plume as defined to the pathway-specific target level and between the source and the receptor; and (3) a guard well meaning a monitoring well between the source and the point of exposure with concentrations below the SSTL line. (NOTE: Monitoring under this provision may be used to satisfy exit monitoring if it otherwise meets the criteria in 135.12(6).)

d. Soil monitoring.

(1) For the soil vapor to enclosed space pathway potential receptors, soil gas samples must be taken at a minimum of once per year in the area(s) of expected maximum vapor concentrations where an institutional control is not in place.

(2) For the soil leaching to groundwater pathway potential receptors, annual groundwater monitoring is required for a minimum of three years as provided in *"c"* above. If groundwater concentrations are below the applicable SSTL line for all three years and a final soil sample taken from the source shows no significant vertical movement, no further action is required. If groundwater concentrations exceed the applicable SSTL line in any of the three years, corrective action is required to reduce soil concentrations to below the Tier 1 levels for soil leaching to groundwater. Therefore, annual monitoring of soil is not applicable.

(3) For the soil to plastic water line pathway potential receptors, notification of the utility company is required. Notification will result in reclassification to no action required. Therefore, annual monitoring of soil is not applicable.

e. Receptors must be evaluated at least annually to ensure no actual or modeled data are above the site-specific target level line for any actual receptors. Potential receptor areas of concern must be evaluated at least annually and the presence of no actual receptors confirmed. If actual receptors are present or reasonably expected to be brought into existence, the owner or operator must report this fact to the department as soon as practicable. Annual monitoring which also meets the exit criteria under 135.12(6) may be used for that purpose.

f. The site or pathway must meet exit monitoring criteria to be reclassified as no action required as specified in 135.12(6)*"b."* If concentrations for actual receptors increase above the site-specific target level line or potential receptor status changes to actual receptor status, the site must be reclassified as high risk and further corrective action required in accordance with 135.12(3).

135.12(6) *No action required classification.* A site shall be classified as no action required if all of the pathways are classified as no action required as provided below:

a. Soil pathways shall be classified as no action required if samples are less than the applicable target levels as defined for each pathway and confirmational sampling requirements have been met.

b. For initial classification, groundwater pathways shall be classified as no action required if the field data is below the site-specific target level line and all field data is at or less than the simulation line, and confirmation monitoring has been completed successfully. Confirmation sampling for groundwater and soil is a second sample which confirms the no action required criteria.

c. For reclassification from high or low risk, a pathway shall be classified as no action required if all field data is below the site-specific target level line and if exit monitoring criteria have been met. Exit monitoring criteria means the three most recent consecutive groundwater samples from all monitoring wells must show a steady or declining trend and the most recent samples are below the site-specific target level line. Other criteria include the following: The first of the three samples for the source well and transition well must be more than detection

limits; concentrations cannot increase more than 20 percent from the first of the three samples to the third sample; concentrations cannot increase more than 20 percent of the previous sample; and samples must be separated by at least six months.

d. Confirmation sampling for soil gas and indoor vapor. For the enclosed space pathways, confirmation sampling is required to reasonably establish that the soil gas and indoor vapor samples represent the highest expected levels. A groundwater professional must obtain two samples taken at least two weeks apart. One of the samples must be taken during a seasonal period of lowest groundwater elevation and soil gas samples must be taken below the frost line.

e. Upon site classification as no action required, all groundwater monitoring wells must be properly plugged in accordance with 567—Chapters 39 and 49 unless the department requires selected wells to be maintained or written approval to maintain the well is obtained by the department.

135.12(7) *Reclassification.* Any site or pathway which is classified as high risk may be reclassified to low risk if in the course of corrective action the criteria for low risk classification are established. Any site or pathway which is classified as low risk may be reclassified to high risk if in the course of monitoring the conditions for high risk classification are established. Sites subject to department-approved institutional or technological controls are classified as no action required if all other criteria for no action required classification are satisfied.

135.12(8) *Use of institutional and technological controls.*

a. Purpose. The purpose of an institutional control is to restrict access to or use of property such that an applicable receptor could not be exposed to chemicals of concern for as long as the target level is exceeded at applicable points of exposure and compliance. Institutional controls include:

1. A law of the United States or the state;
2. A regulation issued pursuant to federal or state laws;
3. An ordinance or regulation of a political subdivision in which real estate subject to the institutional control is located;
4. An environmental covenant as provided in 2005 Iowa Code Supplement section 455B.474(1)*"f"*(4)(f) and in accordance with the provisions of 2005 Iowa Code Supplement chapter 455I and 567—Chapter 14;
5. Any other institutional control the owner or operator can reasonably demonstrate to the department will reduce the risk from a release throughout the period necessary to ensure that no applicable target level is likely to be exceeded.

b. Modification or termination of institutional and technological controls. At a point when the department determines that an institutional or technological control has been removed or is no longer effective for the purpose intended, regardless of the issuance of a no further action certification or previous site classification, it may require owners and operators to undertake such reevaluation of the site conditions as necessary to determine an appropriate site classification and corrective action response. If the owner or operator is in control of the affected property, the department may require reimplementation of the institutional or technological control or may require a Tier 2 assessment of the affected pathway(s) be conducted to reevaluate the site conditions and determine alternative corrective action response. An owner or operator subject to an institutional or technological control may request modification or termination of the control by conducting a Tier 2 assessment of the affected pathway or conduct such other assessment as required by the department to establish that the control is no longer required given current site conditions.

c. If the owner or operator is not in control of the affected property or cannot obtain control and the party in control refuses to continue implementation of an institutional control, the department may require the owner or operator to take such legal action as available to enforce institution of the control or may require the owner or operator to undertake a Tier 2 assessment to determine site classification and an alternative corrective action response. If a person in control of the affected property appears to be contractually obligated to maintain an institutional or technological control, the department may, but is not required to, attempt enforcement of the contractual obligation as an alternative to requiring corrective action by the owner or operator.

d. If a site is classified no action required, subject to the existence of an institutional control or technological control, the holder of the fee interest in the real estate subject to the institutional control or technological control may request, at any time, that the department terminate the institutional control or technological control requirement. The department shall terminate the requirement for an institutional control if the holder demonstrates by completion of a Tier 2 assessment of the applicable pathway or other assessment as required by the department that the site conditions warranting the control no longer exist and that the site or pathway has met exit criteria for no action required classification under 135.12(6).

135.12(9) *Corrective action design report submission and review procedures.*

a. Owners and operators must submit a corrective action design report (CADR) within 60 days of the date the department approves or is deemed to approve a Tier 2 assessment report under 135.10(11) or a Tier 3 assessment is to be conducted. The department may establish an alternative schedule for submittal. As an alternative to submitting a CADR, owners or operators may participate in a corrective action meeting process to develop a corrective action plan which would be incorporated into a memorandum of agreement or other written agreement approved by the department. Owners or operators shall implement the terms of an approved CADR, memorandum of agreement or other corrective action plan agreement.

b. Corrective action design report completeness and accuracy. A CADR is considered to be complete if it contains all the information and data required by this rule and the department's guidance. The report is considered accurate if the information and data are reasonably reliable based first on the standards in these rules and department guidance, and second, on generally accepted industry standards.

c. The certified groundwater professional responsible for completion of the CADR must provide the following certification with the CADR:

I, _____, groundwater professional certification number _____, am familiar with all applicable requirements of Iowa Code section 455B.474 and all rules and procedures adopted thereunder including, but not limited to, the Department of Natural Resources' guidance and specifications for corrective action design reports. Based on my knowledge of those documents and the information I have prepared and reviewed regarding this site, UST registration number _____, LUST No._____, I certify that this document is complete and accurate as provided in 135.12(9) and meets the applicable requirements of the corrective action design report, and that the recommended corrective action can reasonably be expected to meet its stated objectives.

Signature

Date

d. Review. Unless the report proposes to classify the site as no action required, the department must approve the report within 60 days for purposes of completeness or disapprove the report upon a finding of incompleteness, inaccuracy or noncompliance with these rules. If no decision is made within this 60-day period, the report is deemed to be approved for purposes of completeness. The department retains the authority to review the report at any time a no action required site classification is proposed. Owners or operators who fail to implement actions or meet the activity schedule in a memorandum of agreement resulting from a corrective action meeting or other written corrective action plan agreement or who fail to implement the actions or schedule outlined in an approved CADR are subject to legal action.

e. No action required site classification review. The department will review each CADR which proposes to classify a site as no action required to determine the data and information are complete and accurate, the data and information comply with department rules and guidance and the site classification proposal is reasonably supported by the data and information.

135.12(10) *Monitoring certificates and no further action certificates.*

a. Monitoring certificate. The department of natural resources will issue a monitoring certificate to the owner or operator of an underground storage tank from which a release has occurred, the current property owner, or other responsible party who has undertaken the corrective action warranting issuance of the certificate. Sites classified as low risk or sites classified as high risk/monitoring shall be eligible for a monitoring certificate. The monitoring certificate will be valid until the site is reclassified to a high risk requiring active remediation or no action required site. A site which has been issued a monitoring certificate shall not be eligible to receive a certificate evidencing completion of remediation until the site is reclassified as no action required. The monitoring certificate will be invalidated and the site reclassified to high risk if it is determined by the department that the owner of the site is not in compliance with the requirements specified in the monitoring certificate.

b. No further action certificate. The department will issue a no further action certificate to an owner or operator of an underground storage tank from which a release has occurred, the current property owner or other responsible party who has undertaken the corrective action warranting classification of the site as no action required. The person requesting the certificate shall provide the department with an accurate legal description of the property on which the underground storage tanks are or were formerly located. The following conditions apply:

(1) The site has been determined by a certified groundwater professional to not present an unreasonable risk to the public health and safety or the environment;

(2) A person issued the certificate or a subsequent purchaser of the site cannot be required to perform further corrective action solely because action standards are changed at a later date. Action standards refer to applicable site-specific standards under this rule;

(3) The certificate shall not prevent the department from ordering remediation of a new release or a release of a regulated substance from an unregulated tank;

(4) The certificate will not constitute a warranty of any kind to any person as to the condition, marketability or value of the described property;

(5) The certificate shall reflect any institutional control utilized to ensure compliance with any applicable Tier 2 level; and may include a notation that the classification is based on the fact that designated potential receptors are not in existence;

(6) The certificate shall be in a form which is recordable in accordance with Iowa Code section 558.1 et seq. and substantially in the form as provided in Appendix C.

c. The department shall modify any issued no further action certificates containing institutional controls once the owner, operator or their successor or assign has demonstrated that the institutional control is no longer necessary to meet the applicable Tier 2 level as provided in 135.12(10).

135.12(11) *Expedited corrective action.* An owner, operator or responsible party of a site at which a release of regulated substance is suspected to have occurred may carry out corrective actions at the site so long as the department receives notice of the expedited cleanup activities within 30 calendar days of their commencement; the owner, operator, or responsible party complies with the provisions of these rules; and the corrective action does not include active treatment of groundwater other than:

a. As previously approved by the department; or

b. Free product recovery pursuant to subrule 135.7(5).

c. Soil excavation. When undertaking excavation of contaminated soils, adequate field screening methods must be used to identify maximum concentrations during excavation. At a minimum one soil sample must be taken for field screening every 100 square feet of the base and each sidewall. Soil samples must be taken for laboratory analysis at least every 400 square feet of the base and each sidewall of the excavated area to confirm remaining concentrations are below Tier 1 levels. If the excavation is less than 400 square feet, a minimum of one sample must be analyzed for each sidewall and the base. The owner or operator must maintain adequate records of the excavation area to document compliance with this procedure unless submitted to the department and must provide it to the department upon request.

567—135.13(455B) Public participation.

135.13(1) For each confirmed release that is classified as high or low risk, the department must provide notice to the public by means designated to reach those members of the public directly affected by the release and the recommended corrective action response. This notice may include, but is not limited to, public notice in local newspapers, block advertisements, public service announcements, publication in a state register, letters to individual households, or personal contacts by the staff.

135.13(2) The department must ensure site release information and decisions concerning the Tier 1 assessment report, Tier 2 and Tier 3 site cleanup reports are made available to the public for inspection upon request.

135.13(3) Before approving the Tier 2 or Tier 3 site cleanup report, the department may hold a public meeting to consider comments on the proposed corrective action response if there is sufficient public interest, or for any other reason.

135.13(4) The department must give a public notice that complies with subrule 135.13(1) above if the implementation of the approved Tier 2 or Tier 3 site cleanup report does not achieve the established cleanup levels in the report and the termination of that report is under consideration by the department.

567—135.14(455B) Action levels. The following corrective action levels apply to petroleum regulated substances as regulated by this chapter. These action levels shall be used to determine if further corrective action under 135.6(455B) through 135.12(455B) or 135.15(455B) is required as the result of tank closure sampling under 135.15(3) or other analytical results submitted to the department. The contaminant concentrations must be determined by laboratory analysis as stated in 135.16(455B). Final cleanup determination is not limited to these contaminants. The contamination corrective action levels are:

	Soil (mg/kg)	Groundwater (ug/L)
Benzene	0.54	5
Toluene	42	1,000
Ethylbenzene	15	700
Xylenes	No limit	10,000
Total Extractable Hydrocarbons	3,800	1,200

567—135.15(455B) Out-of-service UST systems and closure.

135.15(1) *Temporary closure.*

a. When a UST system is temporarily closed, owners and operators must continue operation and maintenance of corrosion protection in accordance with 135.4(2), any release detection in accordance with rule 135.5(455B), and financial responsibility in accordance with 567—Chapter 136. Rules 135.6(455B) to 135.12(455B) must be complied with if a release is suspected or confirmed. However, release detection is not required as long as the UST system is empty. The UST system is empty when all materials have been removed using commonly employed practices so that no more than 2.5 centimeters (1 inch) of residue, or 0.3 percent by weight of the total capacity of the UST system, remain in the system.

b. When a UST system is temporarily closed for three months or more, owners and operators must notify the department in writing of the temporary closure and comply with the following requirements:

(1) Leave vent lines open and functioning; and

(2) Cap and secure all other lines, pumps, accesses, and ancillary equipment.

c. When a UST system is temporarily closed for more than 12 months, owners and operators must return the tank tags and permanently close the UST system if it does not meet either the performance standards in 135.3(1) for new UST systems or the upgrading requirements in 135.3(2), except that the spill and overfill equipment requirements do not have to be met. Owners and operators must permanently close the substandard UST systems at the end of this 12-month period in accordance with 135.15(2) to 135.15(5), unless the department provides an extension of the 12-month temporary closure period. Owners and operators must complete a site assessment in accordance with 135.15(3) before such an extension can be applied for.

135.15(2) *Permanent closure and changes-in-service.*

a. At least 30 days before beginning either permanent closure or a change-in-service under paragraphs *"b"* and *"c"* below, owners and operators must notify the department of their intent to permanently close or make the change-in-service. An owner or operator must seek prior approval to permanently close a tank in a time frame shorter than the 30-day notice. The required assessment of the excavation zone under 135.15(3) must be performed after notifying the department but before completion of the permanent closure or a change-in-service.

b. To permanently close a tank or piping, owners and operators must empty and clean them by removing all liquids and accumulated sludge. All tanks taken out of service permanently must also be either removed from the ground or filled with an inert solid material. Piping must either be removed from the ground or have the ends plugged with an inert solid material.

When permanently closing a tank by filling with inert solid material, the tank may not be filled until a closure report is approved by the department. The tank must be filled within 30 days after department approval. The owner and operator must notify the department within 15 days after filling the tank with inert solid material.

c. Continued use of a UST system to store a nonregulated substance is considered a change-in-service. Before a change-in-service, owners and operators must empty and clean the tank by removing all liquid and accumulated sludge and conduct a site assessment in accordance with 135.15(3).

d. Permanent closure procedures must be followed in the replacement of tanks or piping. Notification must be made using DNR Form 542-1308, "Notification of Tank Closure or Change-in-Service." The form must include the date scheduled for the closure. Oral confirmation of the closure date must be given to the DNR field office 24 hours prior to the actual closure. The required assessment of the excavation zone under 139.15(3) must be performed after notifying the department but before completion of the permanent closure or change-in-service.

NOTE: The following cleaning and closure procedures may be used to comply with subrule 135.15(2): American Petroleum Institute Recommended Practice 1604, "Removal and Disposal of Used Underground Petroleum Storage Tanks"; American Petroleum Institute Publication 2015, "Cleaning Petroleum Storage Tanks"; American Petroleum Institute Recommended Practice 1631, "Interior Lining of Underground Storage Tanks,"

may be used as guidance for compliance with this subrule; and the National Institute for Occupational Safety and Health "Criteria for a Recommended Standard . . . Working in Confined Space" may be used as guidance for conducting safe closure procedures at some hazardous substance tanks.

135.15(3) *Assessing the site at closure or change-in-service.*

a. Before permanent closure or a change-in-service is completed, owners or operators must measure for the presence of a release where contamination is most likely to be present at the UST site. In selecting the sample types, sample locations, and measurement methods, owners and operators must consider the method of closure, the nature of the stored substance, the type of backfill, the depth to groundwater, and other factors appropriate for identifying the presence of a release.

At UST sites with a history of petroleum storage, soil and groundwater samples shall in every case be analyzed for benzene, toluene, ethylbenzene, and xylenes (BTEX) with each compound reported separately in accordance with 135.16(455B). If there has been a history or suspected history of petroleum storage other than gasoline or gasoline blends (i.e., all grades of diesel fuels, fuel oil, kerosene, oil and mineral spirits), or such storage history is unknown or uncertain, soil and groundwater samples shall also be analyzed for total extractable hydrocarbons in accordance with 135.16(455B).

All such samples shall be collected separately and shipped to a laboratory certified under 567—Chapter 42, Part C, within 72 hours of collection. Samples shall be refrigerated and protected from freezing during shipment to the laboratory.

When an UST is removed from an area of confirmed contamination, the department may waive closure sampling if written documentation is submitted with the closure notification. Documentation should include laboratory analytical reports and a site map showing tank and piping locations along with contamination plume and sampling locations.

b. For all permanent tank and piping closures or changes-in-service, at least one water sample must be taken from the first saturated groundwater zone via a monitoring well or borehole except as provided in paragraph *"g."* The well or borehole must be located downgradient from and as close as possible to the excavation but no farther away than 20 feet.

If, however, the first saturated groundwater zone is not encountered within 10 feet below the lowest elevation of the tank excavation, the requirement for groundwater sampling shall not apply unless:

(1) Sands or highly permeable soils are encountered within 10 feet below the lowest level of the tank excavation which together with the underlying geology would, in the judgment of the department, pose the reasonable possibility that contamination may have reached groundwaters deeper than 10 feet below the lowest level of the tank excavation. The method of determining highly permeable soil is found in the departmental guidance documents entitled "Underground Storage Tank Closure Procedures for Tank and Piping Removal" and "Underground Storage Tank Closure for Filling in Place."

(2) Indications of potential groundwater contamination, including petroleum products in utility lines, petroleum products in private wells, petroleum product vapors in basements or other structures, occur in the area of the tank installation undergoing closure or change-in-service.

c. For permanent closure by tank removal, the departmental guidance document entitled "Underground Storage Tank Closure Procedures for Tank and Piping Removal" must be followed. The minimum number of soil samples that must be taken depends on the tank size and length of product piping. Samples must be taken at a depth of 1 to 2 feet beneath the tank fill area below the base of the tank along the tank's centerline. Soil samples must also be taken at least every 10 feet along the product piping at a depth of 1 to 2 feet beneath the piping fill area below the piping.

If sands or other highly permeable soils are encountered, alternative sampling methods may be required.

If contamination is suspected or found in any area within the excavation (i.e., sidewall or bottom), a soil sample must be taken at that location.

The numbers of samples required for tanks are as follows:

Nominal Tank Capacity (gallons)	Number of Samples	Location on Centerline
1,000 or less	1	center of tank
1,001 - 8,000	2	1/3 from ends

Nominal Tank Capacity (gallons)	Number of Samples	Location on Centerline
8,001 - 30,000	3	5 feet from ends and at center of tank
30,001 - 40,000	4	5 and 15 feet from ends
40,001 and more	5	5 and 15 feet from ends and at center of tank

d. For closing a tank in place by filling with an inert solid material or for a change-in-service, the departmental guidance document entitled "Underground Storage Tank Closure for Filling in Place" must be followed. The minimum number of soil borings required for sampling depends on the size of the tank and the length of the product piping. Soil samples must be taken within 5 feet of the sides and ends of the tank at a depth of 2 to 4 feet below the base of the tank, but outside the backfill material, at equal intervals around the tank. Soil samples must also be taken at least every 10 feet along the product piping at a depth of 1 to 2 feet beneath the piping fill area below the piping. If sands or other highly permeable soils are encountered, alternative sampling methods may be required.

The minimum numbers of soil borings and samples required are as follows:

Nominal Tank Capacity (gallons)	Number of Samples	Location of Samples
6,000 or less	4	1 each end and each side
6,001 - 12,000	6	1 each end and 2 each side
12,001 or more	8	1 each end and 3 each side

e. A closure report must be submitted to the department within 45 days of the tank removal or sampling for a closure in place. The report must include all laboratory analytical reports, soil boring and well or borehole construction details and stratigraphic logs, and a dimensional drawing showing location and depth of all tanks, piping, sampling, and wells or boreholes, and contaminated soil encountered. The tank tags must be returned with the closure report.

f. The requirements of this subrule are satisfied if one of the external release detection methods allowed in 135.5(4)*"e"* and *"f"* is operating in accordance with the requirements in 135.5(4) at the time of closure and indicates no release has occurred.

g. If contaminated soils, contaminated groundwater, or free product as a liquid or vapor is discovered during the site assessment or by any other manner, contact the department in accordance with 135.6(1). Normal closure procedures no longer apply. Owners and operators must begin corrective action in accordance with rules 135.7(455B) to 135.12(455B).

Identification of free product requires immediate response in accordance with 135.7(5). If contamination appears extensive or the groundwater is known to be contaminated, a full assessment of the contamination will be required. When a full assessment is required or anticipated, collection of the required closure samples is not required. If contamination appears limited to soils, overexcavation of the contaminated soils in accordance with 135.15(4) may be allowed at the time of closure.

135.15(4) *Overexcavation of contaminated soils at closure.*

a. If contaminated soils are discovered while assessing a site at closure in accordance with 135.15(3), owners and operators may overexcavate up to one foot of the contaminated soils surrounding the tank pit. The contamination and overexcavation must be reported to the department in accordance with the requirements of 135.6(4)*"a"* prior to backfilling the excavation. If excavation is limited to one foot of contaminated soils, a soil sample shall be taken and laboratory analyzed in accordance with 135.16(455B) from the area showing the greatest contamination. Any overexcavation of contaminated soils beyond one foot of contaminated soils is considered expedited corrective action and must be conducted by a certified groundwater professional in accordance with the procedures in 135.12(11).

b. Excavated contaminated soils must be properly disposed in accordance with 567—Chapters 100, 101, 102, 120, and 121, Iowa Administrative Code.

c. A report must be submitted to the department within 30 days of completion of the laboratory analysis. The report must include the requirements of 135.15(3)*"e"* and a dimensional drawing showing the depth and area of the excavation prior to and after overexcavation. The area of contamination must be shown.

135.15(5) *Applicability to previously closed UST systems.* When directed by the department, the owner and operator of a UST system permanently closed before October 24, 1988, must assess the excavation zone and close the UST system in accordance with this rule if releases from the UST may, in the judgment of the department, pose a current or potential threat to human health and the environment.

135.15(6) *Closure records.* Owners and operators must maintain records in accordance with 135.4(5) that are capable of demonstrating compliance with closure requirements under this rule. The results of the excavation zone assessment required in 135.15(3) must be maintained for at least three years after completion of permanent closure or change-in-service in one of the following ways:

a. By the owners and operators who took the UST system out of service;

b. By the current owners and operators of the UST system site; or

c. By mailing these records to the department if they cannot be maintained at the closed facility.

135.15(7) *Applicability to pre-1974 USTs.* The closure provisions of rule 135.15(455B) are not applicable to USTs which have been out of operation as of January 1, 1974. For purposes of this subrule, out of operation means that no regulated substance has been deposited into or dispensed from the tanks and that the tanks do not currently contain an accumulation of regulated substances other than a de minimus amount as provided in 135.15(1)*"a."*

Owners and operators or other interested parties are not required to submit documentation that USTs meet the exemption conditions and may rely on this subrule as guidance. However, should a question arise as to whether USTs meet the exemption, or owners and operators or other interested parties request acknowledgment by the department that USTs are exempt, they must submit an affidavit on a form provided by the department. The affiant must certify that based on a reasonable investigation and to the best of the affiant's knowledge, the USTs were taken out of operation prior to January 1, 1974, the USTs have not contained a regulated substance since January 1, 1974, and the USTs do not currently contain an accumulation of regulated substances.

If the department has a reasonable basis to suspect a release has occurred, the release investigation and confirmation steps of subrule 135.8(1) and the corrective action requirements as provided in 135.7(455B) to 135.8(455B) shall apply.

567—135.16(455B) Laboratory analytical methods for petroleum contamination of soil and water.

135.16(1) *General.* When having soil or water analyzed for petroleum or hazardous substances, owners and operators of UST systems must use a laboratory certified under 567—Chapter 83. In addition they must ensure that all soil and groundwater samples are properly preserved and shipped within 72 hours of collection to a laboratory certified under 567—Chapter 83, for UST petroleum analyses. This rule provides acceptable analytical procedures for petroleum substances and required information that must be provided in all laboratory reports.

135.16(2) *Laboratory report.* All laboratory reports must contain the following information:

a. Laboratory name, address, telephone number and Iowa laboratory certification number. If analytical work is subcontracted to another laboratory, the analytical report from the certified lab which analyzed the sample must be submitted and include the information required in this subrule.

b. Medium sampled (soil, water).

c. Client submitting sample (name, address, telephone number).

d. Sample collector (name, telephone number).

e. UST site address.

f. Clients sample location identifier.

g. Date sample was collected.

h. Date sample was received at laboratory.

i. Date sample was analyzed.

j. Results of analyses and units of measure.

k. Detection limits.

l. Methods used in sample analyses (preparation method, sample detection method, and quantitative method).

m. Laboratory sample number.

n. Analyst name.

o. Signature of analyst's supervisor.

p. Condition in which the sample was received at the laboratory and whether it was properly sealed and preserved.

q. Note that analytical results are questionable if a sample exceeded an established holding time or was improperly preserved. (The recommended holding time for properly cooled and sealed petroleum contaminated samples is 14 days, except for water samples containing volatile organic compounds which have a 7-day holding time unless acid-preserved.)

r. Laboratory reports required by this chapter for tank closure investigations under 135.15(455B) and site checks under 135.6(3) or Tier 1 or Tier 2 assessments under 135.9(455B) to 135.11(455B) must include a copy of the chromatograms and associated quantitation reports for the waste oil, diesel and gasoline standard used by the laboratory in analyzing submitted samples. The laboratory analytical report for each sample must state whether the sample tested matches the laboratory standard for waste oil, diesel or gasoline or that the sample cannot be reliably matched with any of these standards. A copy of the chromatograms and associated quantitation reports for only the soil and groundwater samples with the maximum concentrations of BTEX and TEH must be included.

135.16(3) *Analysis of soil and water for high volatile petroleum compounds (i.e., gasoline, benzene, ethylbenzene, toluene, xylene).* Sample preparation and analysis shall be by Method OA-1, "Method for Determination of Volatile Petroleum Hydrocarbons (gasoline)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa. This method is based on U.S. EPA methods 5030, 8000, and 8015, SW-846, "Test Methods for Evaluating Solid Waste," 3rd Edition. Copies of Method OA-1 are available from the department.

135.16(4) *Analysis of soil and water for low volatile petroleum hydrocarbon contamination (i.e., all grades of diesel fuel, fuel oil, kerosene, oil, and mineral spirits).* Sample preparation and analysis shall be by Method OA-2, "Determination of Extractable Petroleum Products (and Related Low Volatility Organic Compounds)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa. This method is based on U.S. EPA methods 3500, 3510, 3520, 3540, 3550, 8000, and 8100, SW-846, "Test Methods for Evaluating Solid Waste," 3rd Edition. Copies of Method OA-2 are available from the department.

135.16(5) *Analysis of soil gas for volatile petroleum hydrocarbons.* Analysis of soil gas for volatile petroleum hydrocarbons shall be conducted in accordance with the National Institute for Occupational Safety and Health (NIOSH) Method 1501, or a department-approved equivalent method.

567—135.17(455B) Evaluation of ability to pay.

135.17(1) General. The ability to pay guidance procedures referenced in this rule will be used by the department when an owner or operator of an underground storage tank (UST) claims to be financially unable to comply with corrective action requirements under 135.7(455B) to 135.12(455B) or closure investigation requirements under 135.15(455B). If an owner or operator of a regulated UST claims to be financially unable to meet these departmental requirements, that responsible party must provide documentation of the party's finances on forms provided by the department in order for the department to act on the claim of financial inability. The department may request additional financial documentation to verify or supplement reported information.

135.17(2) Individual claims. The financial ability of individual owners and operators of USTs, with or without an active business (including but not limited to sole proprietorships and general partnerships), shall be evaluated using the "Individual Ability to Pay Guidance" document dated June 19, 1992, and generally accepted principles of financial analysis. This guidance is only one tool the department may use in evaluating claims of financial inability.

135.17(3) Corporate claims. The financial ability of corporate owners and operators of USTs shall be evaluated using the June 1992 version of "ABEL" developed by the U.S. Environmental Protection Agency and generally accepted principles of financial analysis. This guidance is only one tool the department may use in evaluating claims of financial inability.

135.17(4) Federal LUST Trust Fund. The financial ability of owners and operators of USTs shall be evaluated for the purpose of determining if the department is authorized to use Federal LUST Trust Fund moneys as provided in the current cooperative agreement with the U.S. Environmental Protection Agency, Region VII. A determination of financial inability does not create an entitlement or any expectation interest on behalf of an owner or operator that Federal LUST Trust Fund moneys will be used for corrective action at any individual site.

135.17(5) The evaluation of financial ability will also be used by the department in making other administrative planning decisions including but not limited to decisions as to whether to pursue and when to pursue administrative or judicial enforcement of regulatory and statutory duties and the assessment of penalties. A determination of financial inability does not create an entitlement or expectation interest that enforcement

actions will be deferred or suspended. The evaluation of this factor is only one of many affecting the department's fully discretionary decisions regarding enforcement options and program planning.

135.17(6) An evaluation of financial inability as provided in this rule does not relieve any owner or operator of legal liability to comply with department rules or Iowa Code chapter 455B or provide a defense to any legal actions to establish liability or enforce compliance.

567—135.18(455B) Transitional rules.

135.18(1) *Transitional rules.* Guidance for implementing these transitional rules is contained in the department's guidance entitled "Transition Policy Statement" dated June 6, 1996.

135.18(2) *Site cleanup reports and corrective action design reports accepted before August 15, 1996.* Any owner or operator who had a site cleanup report or corrective action design report approved by the department before August 15, 1996, may elect to submit a Tier 1 Site Assessment or Tier 2 Site Cleanup Report to the department. If the owner, operator, or responsible party so elects, the site shall be assessed, classified, and, if necessary, remediated, in accordance with the rules of the department as of August 15, 1996. To the extent that data collected for the site cleanup report does not include all information necessary for the Tier 1 Site Assessment or Tier 2 Site Cleanup Report, the owner or operator shall utilize the default parameters set out in subrule 135.18(4) or provide site-specific parameters.

135.18(3) *Site cleanup reports in the process of preparation or review prior to August 15, 1996.* The department will complete a Tier 1 or a Tier 2 risk analysis for any site cleanup report received but not approved by the department by November 15, 1996. To the extent that data collected for the site cleanup report does not include all information necessary for the Tier 2 site cleanup report and the owner or operator elects to not complete a Tier 2 site cleanup report the department shall utilize the default parameters set out in subrule 135.18(4). If the owner or operator wishes that site-specific data, rather than any default parameter, be used, the owner or operator shall notify the department by October 15, 1996, or in accordance with a schedule specified by the department. Following notification, the owner or operator shall be responsible for preparation of the Tier 1 site assessment or Tier 2 site cleanup report.

135.18(4) *Default parameters for use in converting a site cleanup report to a Tier 2 site cleanup report.*

a. As to sites for which the owner or operator has collected and submitted only TPH ("total petroleum hydrocarbons") data regarding soil contamination, TPH levels shall be converted to a risk associated factor by using: (1) previously acquired data regarding benzene, toluene, ethyl benzene, and xylenes data for the samples; (2) newly collected benzene, toluene, ethylbenzene, and xylenes data for the site; or (3) the assumptions that 1 percent of the total petroleum hydrocarbon (TPH) is benzene, 7 percent of the TPH is toluene, 2 percent of the TPH is ethylbenzene, and 8 percent of the TPH is xylenes.

b. As to sites for which the owner or operator has, to date, submitted only TEH ("total extractable hydrocarbons") data regarding soil contamination, TEH levels should be converted to a risk-associated factor by using: (1) previously acquired benzene, toluene, ethylbenzene and xylenes data for the samples; (2) newly collected benzene, toluene, ethylbenzene and xylenes data for the site; or (3) the assumption that 0.004 percent of the TEH is benzene, 0.05 percent of the TEH is toluene, 0.03 percent of the TEH is ethylbenzene and 0.3 percent of the TEH is xylenes. In addition, TEH levels should be compared to the TEH default levels in the Tier 1 Table. If, as of August 15, 1996, only TEH data for soil is available, and it does not exceed Tier 1 levels, additional sampling for TEH in groundwater is not required. Otherwise, groundwater samples must be collected and analyzed for TEH in accordance with 135.8(3).

c. Data required for preparing a Tier 2 site cleanup report shall be taken from the site cleanup report. If the site cleanup report lacks any of the data, site-specific data subsequently obtained may be used. The following assumptions shall be used if no site cleanup report or site-specific data is provided:

(1) If the site cleanup report is unclear as to neighboring land use, assume the land residential land use;

(2) Use the larger resulting default if both TPH and TEH data are available.

(3) For sites with free product gasoline range constituents, the default values in groundwater are 17,500 ug/l for benzene, 3,040 ug/l for ethylbenzene, 37,450 ug/l for toluene and 15,840 ug/l for xylenes. For sites with free product consisting of diesel range constituents, the default values are 370 ug/l benzene, 640 ug/l toluene, 140 ug/l ethylbenzene, 580 ug/l xylenes, and 260 ug/l naphthalene or 130,000 ug/l TEH.

135.18(5) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports accepted before August 6, 2008.* Any owner or operator who had a Tier 2 site cleanup report, Tier 3 report, or corrective action design report approved by the department before August 6, 2008, may elect to

submit a Tier 2 site cleanup report using the Appendix B revised model, department-developed software and rules in effect as of August 6, 2008. The owner or operator shall notify the department that the owner or operator wishes to evaluate the leaking underground storage tank site with the Appendix B revised model, software and rules. If the owner or operator so elects, the site shall be assessed, classified, and, if necessary, remediated, in accordance with the rules of the department as of August 6, 2008. If the leaking underground storage tank site is undergoing active remediation, the remediation system shall remain operating until the reevaluation is completed and accepted or as otherwise approved by the department. Once a site has been evaluated using the Appendix B revised model, software and rules in effect as of August 6, 2008, it can no longer be evaluated with the Appendix B-1 old model and software and rules in effect prior to August 6, 2008.

135.18(6) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports in the process of preparation with a submittal schedule established prior to August 6, 2008.* The owner or operator shall notify the department that the owner or operator wishes to use the Appendix B revised model and department software and rules in effect as of August 6, 2008, to evaluate the leaking underground storage tank site before submitting the next report, and prior to expiration of the previously established submittal schedule. Once a site has been evaluated using the Appendix B revised model, software and rules in effect as of August 6, 2008, it can no longer be evaluated with the Appendix B-1 old model, software and rules existing just prior to August 6, 2008.

135.18(7) *Risk-based corrective action assessment reports, corrective action plans, and corrective action design reports received by the department but not yet reviewed.* The owner or operator will notify the department within 60 days of August 6, 2008, whether the owner or operator is electing to complete a risk-based corrective action assessment using Appendix B revised model, department software and rules effective as of August 6, 2008, or proceeding with the risk-based corrective action assessment using Appendix B-1 old model and department software and rules existing prior to August 6, 2008. Once a site has been evaluated using the Appendix B revised model, software and rules it can no longer be evaluated with the previous Appendix B-1 old model, software and rules.

567—135.19(455B) Analyzing for methyl tertiary-butyl ether (MTBE) in soil and groundwater samples.

135.19(1) *General.* The objective of analyzing for MTBE is to determine its presence in soil and water samples collected as part of investigation and remediation of contamination at underground storage tank facilities.

135.19(2) *Required MTBE testing.* Soil and water samples must be analyzed for MTBE when collected for risk-based corrective action as required in rules 135.8(455B) through 135.12(455B). These sampling requirements include but are not limited to:

a. Risk-based corrective action (RBCA) evaluations required for Tier 1, Tier 2, and Tier 3 assessments and corrective action design reports.

b. Site monitoring.

c. Site remediation monitoring.

135.19(3) *MTBE testing not required.* Soil and water samples for the following actions are not required to be analyzed for MTBE:

a. Closure sampling under rule 135.15(455B) unless Tier 1 or Tier 2 sampling is being performed.

b. Site checks under subrule 135.7(3) unless Tier 1 or Tier 2 sampling is being performed.

c. If prior analysis at a site under 135.19(2) has not shown MTBE present in soil or groundwater.

d. If the department determines MTBE analysis is no longer needed at a site.

135.19(4) *Reporting.* The analytical data must be submitted in a format prescribed by the department.

135.19(5) *Analytical methods for methyl tertiary-butyl ether (MTBE).* When having soil or water analyzed for MTBE from contamination caused by petroleum or hazardous substances, owners and operators of UST systems must use a laboratory certified under 567—Chapter 83 for petroleum analyses. In addition, the owners and operators must ensure all soil and water samples are properly preserved and shipped within 72 hours of collection to a laboratory certified under 567—Chapter 83 for petroleum analyses.

a. Sample preparation and analysis shall be by:

(1) GC/MS version of OA-1, "Method for Determination of Volatile Petroleum Hydrocarbons (gasoline)," revision 7/27/93, University Hygienic Laboratory, Iowa City, Iowa; or

(2) U.S. Environmental Protection Agency Method 8260B, SW-846, "Test Methods for Evaluating Solid Waste," Third Edition.

b. Laboratories performing the analyses must run standards for MTBE on a routine basis, and standards for other possible compounds like ethyl tertiary-butyl ether (ETBE), tertiary-amyl methyl ether (TAME), diisopropyl ether (DIPE), and tertiary-butyl alcohol (TBA) to be certain of their identification should they be detected.

c. Laboratories must run a method detection limit study and an initial demonstration of capability for MTBE. These records must be kept on file.

d. The minimum detection level for MTBE in soil is 15 ug/kg. The minimum detection level for MTBE in water is 15 ug/l.

567—135.20(455B) Compliance inspection of UST system.

135.20(1) The owner or operator must have the UST system inspected and an inspection report submitted to the department on a biennial basis by an UST compliance inspector certified by the department under 567—Chapter 134. The initial site inspection shall be submitted to the department no later than December 31, 2007.

135.20(2) Compliance inspection requirements. The owner or operator is responsible to ensure the department receives ten days' prior notice by the compliance inspector of the date of a site inspection and the name of the inspector as provided in 567—134.14(455B). The owner and operator must comply with the following as part of the inspection process.

a. Review and respond to the inspection report provided by the certified compliance inspector and complete the corrective actions specified in the compliance inspection report within the specified time frames.

b. Provide all records and documentation required by the certified compliance inspector and this chapter.

c. Upon notification of a suspected release by the certified compliance inspector pursuant to 567—subrule 134.14(1), report the condition to the department and undertake steps to investigate and confirm the suspected release as provided in 567—135.6(455B).

d. Ensure that the compliance inspector completes and submits an electronic inspection form in accordance with 567—134.14(455B).

135.20(3) The owner and operator shall do the following upon receipt of a compliance inspection report as provided in 567—subrule 134.14(1) which finds violations of the department's rules:

a. Take all actions necessary to correct any compliance violations or deficiencies in accordance with this chapter. Corrective action must be taken within the time frame established by rule or, if no time frames are established by rule, within 60 days of receipt of the inspector's report or another reasonable time period approved by the department. The granting of time to remedy a violation does not preclude the department from exercising its discretion to assess penalties for the violation.

b. Within 60 days of receipt of the inspector's report, provide documentation to the compliance inspector that the violation or deficiencies have been corrected.

c. Conduct a follow-up inspection in instances where there are serious problems or a history of repeated violations when required by the department.

Appendix A - Tier 1 Table, Assumptions, Equations and Parameter Values

Iowa Tier 1 Look-Up Table

Media	Exposure Pathway	Receptor	Group 1				Group 2: TEH	
			Benzene	Toluene	Ethylbenzene	Xylenes	Diesel*	Waste Oil
Groundwater (ug/L)	Groundwater Ingestion	actual	5	1,000	700	10,000	1,200	400
		potential	290	7,300	3,700	73,000	75,000	40,000
	Groundwater Vapor to Enclosed Space	all	1,540	20,190	46,000	NA	2,200,000	NA
	Groundwater to Plastic Water Line	all	290	7,300	3,700	73,000	75,000	40,000
	Surface Water	all	290	1,000	3,700	73,000	75,000	40,000
Soil (mg/kg)	Soil Leaching to Groundwater	all	0.54	42	15	NA	3,800	NA
	Soil Vapor to Enclosed Space	all	1.16	48	79	NA	47,500	NA
	Soil to Plastic Water Line	all	1.8	120	43	NA	10,500	NA

NA: Not applicable. There are no limits for the chemical for the pathway, because for groundwater pathways the concentration for the designated risk would be greater than the solubility of the pure chemical in water, and for soil pathways the concentration for the designated risk would be greater than the soil concentration if pure chemical were present in the soil.

TEH: Total Extractable Hydrocarbons. The TEH value is based on risks from naphthalene, benzo(a)pyrene, benz(a)anthracene, and chrysene. Refer to Appendix B for further details.

Diesel*: Standards in the Diesel column apply to all low volatile petroleum hydorcarbons except waste oil.

Assumptions Used for Iowa Tier 1 Look-Up Table Generation

1. Groundwater ingestion pathway. The maximum contaminant levels (MCLs) were used for Group 1 chemicals. The target risk for carcinogens for actual receptors is 10^{-6} and for potential receptors is 10^{-4}. A hazard quotient of one, and residential exposure and building parameters are assumed.

2. Groundwater vapor to enclosed space pathway. Residential exposure and residential building parameters are assumed; no inhalation reference dose is used for benzene; the capillary fringe is assumed to be the source of groundwater vapor; and the hazard quotient is 1 and target risk for carcinogens is $1x10^{-4}$.

3. Groundwater to plastic water line. This pathway uses the same assumptions as the groundwater ingestion pathway for potential receptors, including a target risk for carcinogens of 10^{-4}.

4. Surface water. This pathway uses the same assumptions as the groundwater ingestion pathway for potential receptors, including a target risk for carcinogens of 10^{-4}, except for toluene which has a chronic level for aquatic life of 1,000 as in the definition for surface water criteria in 567—135.2.

5. Soil leaching to groundwater. This pathway assumes the groundwater will be protected to the same levels as the groundwater ingestion pathway for potential receptors, using residential exposure and a target risk for carcinogens of 10^{-4}.

6. Soil vapor to enclosed space pathway. The target risk for carcinogens is $1x10^{-4}$; the hazard quotient is 1; no inhalation reference dose is used for benzene; residential exposure factors are assumed; and the average of the residential and nonresidential building parameters are assumed.

7. Soil to plastic water line pathway. This pathway uses the soil leaching to groundwater model with nonresidential exposure and a target risk for carcinogens of 10^{-4}

In addition to these assumptions, the equations and parameter values used to generate the Iowa Tier 1 Look-Up Table are described below.

Groundwater Ingestion Equations

Carcinogens:

$$RBSL_w \left[\frac{mg}{L - H_2O}\right] = \frac{TR \times BW \times AT_c \times \frac{365\ days}{year}}{SF_o \times IR_w \times EF \times ED}$$

Noncarcinogens:

$$RBSL_w \left[\frac{mg}{L - H_2O}\right] = \frac{THQ \times RfD_o \times BW \times AT_n \times \frac{365\ days}{year}}{IR_w \times EF \times ED}$$

Soil Leaching to Groundwater Equations

$$RBSL_{sl}\left[\frac{mg}{kg - soil}\right] = \frac{RBSL_w\left[\frac{mg}{L - H_2O}\right]}{LF}$$

$$LF\left[\frac{mg/L - H_2O}{mg/kg - soil}\right] = \frac{\rho_s}{(\theta_{ws} + k_s\rho_s + H\theta_{as})\left(1 + \frac{U\delta}{IW}\right)}$$

Soil Vapor to Enclosed Space Equations

$$RBSL_{sv}\left[\frac{mg}{kg-soil}\right] = \frac{RBSL_{air}\left[\frac{\mu g}{m^3-air}\right]}{VF_{sv}}\left(\frac{mg}{1000\ \mu g}\right)$$

$$VF_{sv}\left[\frac{(mg/m^3-air)}{(mg/kg-soil)}\right] = \frac{\frac{H\rho_s}{(\theta_{ws}+k_s\rho_s+H\theta_{as})}\left[\frac{D_s^{eff}/L_s}{ER\ L_B}\right]}{1+\left[\frac{D_s^{eff}/L_s}{ER\ L_B}\right]+\left[\frac{D_s^{eff}/L_s}{\left(D_{crack}^{eff}/L_{crack}\right)\eta}\right]}\left(10^3\ \frac{cm^3-kg}{m^3-g}\right)$$

$$D_{crack}^{eff}\left[\frac{cm^2}{s}\right] = D^{air}\ \frac{\theta_{acrack}^{3.33}}{\theta_T^2} + D^{wat}\frac{1}{H}\frac{\theta_{wcrack}^{3.33}}{\theta_T^2}$$

$$D_s^{eff}\left[\frac{cm^2}{s}\right] = D^{air}\ \frac{\theta_{as}^{3.33}}{\theta_T^2} + D^{wat}\frac{1}{H}\frac{\theta_{ws}^{3.33}}{\theta_T^2}$$

Indoor Air Inhalation Equations

Carcinogens:

$$RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right] = \frac{TR \times BW \times AT_c \times \frac{365\ days}{year} \times \frac{1000\ \mu g}{mg}}{SF_i \times IR_{air} \times EF \times ED}$$

Noncarcinogens:

$$RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right] = \frac{THQ \times RfD_i \times BW \times AT_n \times \frac{365}{\frac{kdays}{year}} \times \frac{1000\ \mu g}{mg}}{IR_{air} \times EF \times ED}$$

Groundwater Vapor to Enclosed Space Equations

$$RBSL_{gw}\left[\frac{mg}{L - H_2O}\right] = \frac{RBSL_{air}\left[\frac{\mu g}{m^3 - air}\right]}{VF_{gw}}\left(\frac{mg}{1000\ \mu g}\right)$$

$$VF_{gw}\left[\frac{(mg/m^3 - air)}{(mg/L - H_2O)}\right] = \frac{H\left[\frac{D_s^{eff}/L_{gw}}{ER\ L_B}\right]}{1 + \left[\frac{D_s^{eff}/L_{gw}}{ER\ L_B}\right] + \left[\frac{D_s^{eff}/L_{gw}}{\left(D_{crack}^{eff}/L_{crack}\right)\eta}\right]}\left(\frac{10^3 L}{m^3}\right)$$

Variable Definitions

δ	groundwater mixing zone thickness (cm)
η	areal fraction of cracks in foundation/wall (cm^2-cracks/cm^2-area)
ρ_s	soil bulk density (g/cm^3)
θ_{acrack}	volumetric air content in foundation/wall cracks (cm^3-air/cm^3-soil)
θ_{as}	volumetric air content in vadose zone (cm^3-air/cm^3-soil)
θ_T	total soil porosity (cm^3-voids/cm^3-soil)
θ_{wcrack}	volumetric water content in foundation/wall cracks (cm^3-H_2O/cm^3-soil)
θ_{ws}	volumetric water content in vadose zone (cm^3-H_2O/cm^3-soil)
AT_c	averaging time for carcinogens (years)
AT_n	averaging time for noncarcinogens (years)
BW	body weight (kg)
D^{air}	chemical diffusion coefficient in air (cm^2/s)
D^{wat}	chemical diffusion coefficient in water (cm^2/s)
D^{eff}_{crack}	effective diffusion coefficient through foundation cracks (cm^2/s)
D^{eff}_{s}	effective diffusion coefficient in soil based on vapor-phase concentration (cm^2/s)
ED	exposure duration (years)
EF	exposure frequency (days/year)
ER	enclosed space air exchange rate (s^{-1})
f_{oc}	fraction organic carbon in the soil (kg-C/kg-soil)
H	henry's law constant (L-H_2O)/(L-air)
i	groundwater head gradient (cm/cm)
I	infiltration rate of water through soil (cm/year)
IR_{air}	daily indoor inhalation rate (m^3/day)
IR_w	daily water ingestion rate (L/day)
K	hydraulic conductivity (cm/year)
K_{oc}	carbon-water sorption coefficient (L-H_2O/kg-C)
k_s	soil-water sorption coefficient (L-H_2O/kg-soil), f_{oc} x K_{oc}
L_B	enclosed space volume/infiltration area ratio (cm)
L_{crack}	enclosed space foundation or wall thickness (cm)
LF	leaching factor from soil to groundwater ((mg/L-H_2O)/(mg/kg-soil))
L_{gw}	depth to groundwater from the enclosed space foundation (cm)
L_s	depth to subsurface soil sources from the enclosed space foundation (cm)
$RBSL_{air}$	Risk-Based Screening Level for indoor air ($\mu g/m^3$-air)
$RBSL_{gw}$	Risk-Based Screening Level for vapor from groundwater to enclosed space air inhalation (mg/L-H_2O)
$RBSL_{sl}$	Risk-Based Screening Level for soil leaching to groundwater (mg/kg-soil)
$RBSLs_v$	Risk-Based Screening Level for vapors from soil to enclosed space air inhalation (mg/kg-soil)
$RBSL_w$	Risk-Based Screening Level for groundwater ingestion (mg/L-H_2O)
RfD_i	inhalation chronic reference dose ((mg/(kg-day))
RfD_o	oral chronic reference dose ((mg/(kg-day))
SF_i	inhalation cancer slope factor ((kg-day)/mg)
SF_o	oral cancer slope factor ((kg-day)/mg)
THQ	target hazard quotient for individual constituents (unitless)
TR	target excess individual lifetime cancer risk (unitless)
U	groundwater Darcy velocity (cm/year), U=Ki
VF_{gw}	volatilization factor for vapors from groundwater to enclosed space ((mg/m^3-air)/(mg/L-H_2O))
VF_{sv}	volatilization factor for vapors from soil to enclosed space ((mg/m^3-air)/(mg/kg-soil))
W	width of soil source area parallel to groundwater flow direction (cm)

Soil and Groundwater Parameter Values Used for Iowa Tier 1 Table Generation

Parameter		Iowa Tier 1 Table Value
K	hydraulic conductivity	16060 cm/year
i	groundwater head gradient	0.01 cm/cm
W	width of soil source area parallel to groundwater flow direction	1500 cm
I	infiltration rate of water through soil	7 cm/year
δ	groundwater mixing zone thickness	200 cm
ρ_s	soil bulk density	1.86 g/cm^3
θ_{as}	volumetric air content in vadose zone	0.2 cm^3-air/cm^3-soil
θ_{ws}	volumetric water content in vadose zone	0.1 cm^3-H_2O/cm^3-soil
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2 cm^3-air/cm^3-soil
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1 cm^3-H_2O/cm^3-soil
θ_T	total soil porosity	0.3 cm^3-voids/cm^3-soil
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm
L_{gw}	depth to groundwater from the enclosed space foundation	1 cm

Exposure Factors Used in Iowa Tier 1 Table Generation

Parameter		Residential	Nonresidential
AT_c (years)	averaging time for carcinogens	70	70
AT_n (years)	averaging time for noncarcinogens	30	25
BW (kg)	body weight	70	70
ED (years)	exposure duration	30	25
EF (days/year)	exposure frequency	350	250
IR_{air} (m^3/day)	daily indoor inhalation rate	15	20
IR_w (L/day)	daily water ingestion rate	2	1
THQ (unitless)	target hazard quotient for individual constituents	1.0	1.0

Building Parameters Used in Iowa Tier 1 Table Generation

Parameter		Residential	Nonresidential
ER (s^{-1})	enclosed space air exchange rate	0.00014	0.00023
L_B (cm)	enclosed space volume/infiltration area ratio	200	300
L_{crack} (cm)	enclosed space foundation or wall thickness	15	15
η	areal fraction of cracks in foundation/wall	0.01	0.01

Chemical-Specific Parameter Values Used for Iowa Tier 1 Table Generation

Chemical	D^{air} (cm^2/s)	D^{wat} (cm^2/s)	H (L-air/L-water)	log(K_{oc}), L/kg
Benzene	0.093	1.1e-5	0.22	1.58
Toluene	0.085	9.4e-6	0.26	2.13
Ethylbenzene	0.076	8.5e-6	0.32	1.98
Xylenes	0.072	8.5e-6	0.29	2.38
Naphthalene	0.072	9.4e-6	0.049	3.11
Benzo(a)pyrene	0.050	5.8e-6	5.8e-8	5.59
Benz(a)anthracene	0.05	9.0e-6	5.74e-7	6.14
Chrysene	0.025	6.2e-6	4.9e-7	5.30

Saturation Values Used to Determine "NA" for the Iowa Tier 1 Table

Chemical	Solubility in Water (mg/L) S	Saturation in Soil (mg/kg) C_s^{sat}
Benzene	1,750	801
Toluene	535	765
Ethylbenzene	152	159
Xylenes	198	492
Naphthalene	31	401
Benzo(a)pyrene	0.0012	4.69
Benz(a)anthracene	0.014	193.3
Chrysene	0.0028	5.59

The maximum solubility of the pure chemical in water is listed in the table above. The equation below is used to calculate the soil concentration (C_s^{sat}) at which dissolved pore-water and vapor phases become saturated. Tier 1 default values are used in the equation. "NA" (for not applicable) is used in the Tier 1 table when the risk-based value exceeds maximum solubility for water (S) or maximum saturation for soil (C_s^{sat}).

$$C_s^{sat}(mg/kg\text{-}soil) = S/\rho_s \times (H\theta_{as} + \theta_{ws} + k_s \rho_s)$$

Slope Factors and Reference Doses Used for Iowa Tier 1 Table Generation

Chemical	SF_i ((kg-day)/mg)	SF_o ((kg-day)/mg)	RfD_i (mg/(kg-day))	RfD_o (mg/(kg-day))
Benzene	0.029	0.029	—	—
Toluene	—	—	0.114	0.2
Ethylbenzene	—	—	0.286	0.1
Xylenes	—	—	2.0	2.0
Naphthalene	—	—	0.004	0.004
Benzo(a)pyrene	6.1	7.3	—	—
Benz(a)anthracene	0.61	0.73	—	—
Chrysene	0.061	0.073	—	—

Appendix B – Tier 2 Equations and Parameter Values (Revised Model)

All Tier 1 equations and parameters apply at Tier 2 except as specified below.

Equation for Tier 2 Groundwater Contaminant Transport Model

Equation (1)

$$C(x) = C_s \exp\left(\frac{x_m}{2\alpha_x}\left[1-\sqrt{1+\frac{4\lambda\alpha_x}{u}}\right]\right) erf\left(\frac{S_w}{4\sqrt{\alpha_y x_m}}\right) erf\left(\frac{S_d}{4\sqrt{\alpha_z x_m}}\right)$$

Equation (2)

Where $x_m = ax + bx^c$

The value of X_m is computed from Equation (2), where the values for a, b and c in Equation (2) are given in Table 1.

Table 1. Parameter Values for Equation (2)

Chemical	a	b	c
Benzene	1	0.000000227987	3.929438689
Toluene	1	0.000030701	3.133842393
Ethylbenzene	1	0.0001	2.8
Xylenes	1	0.0	0.0
TEH-Diesel	1	0.000000565	3.625804634
TEH-Waste Oil	1	0.000000565	3.625804634
Naphthalene	1	0	0

Variable definitions

x: distance in the x direction downgradient from the source
erf( ): the error function
C(x): chemical concentration in groundwater at x
C_s: Source concentration in groundwater (groundwater concentration at x=0)
S_w: width of the source (perpendicular to x)
S_d: vertical thickness of the source
u: groundwater velocity (pore water velocity); u=Ki/θe
K: hydraulic conductivity
i: groundwater head gradient
θe: effective porosity
λ: first order decay coefficient, chemical specific
αx, αy, αz: dispersivities in the x, y and z directions, respectively

For the following lists of parameters, one of three is required: site-specific measurements, defaults or the option of either (which means the default may be used or replaced with a site-specific measurement).

Soil parameters

Parameter		Default Value	Required
ρ_s	soil bulk density	1.86 g/cm^3	option
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil	option
θ_T	total soil porosity	0.3cm^3-voids/cm^3-soil	option
θ_{as}	volumetric air content in vadose zone	0.2cm^3-air/cm^3-soil	default

Parameter		Default Value	Required
θ_{ws}	volumetric water content in vadose zone	0.1cm^3-H_2O/cm^3-soil	default
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2cm^3-air/cm^3-soil	default
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1cm^3-H_2O/cm^3-soil	default
I	infiltration rate of water through soil	7 cm/year	default

If the total porosity is measured, assume 1/3 is air filled and 2/3 is water filled for determining the water and air fraction in the vadose zone soil and floor cracks.

Groundwater Transport Modeling Parameters

Parameter		Default Value	Required
K	hydraulic conductivity	16060 cm/year	site-specific
i	groundwater head gradient	0.01 cm/cm	site-specific
S_w	width of the source	use procedure specified in 135.10(2)	site-specific
S_d	vertical thickness of the source	3 m	default
αx	dispersivity in the x direction	0.1x	default
αy	dispersivity in the y direction	0.33αx	default
αz	dispersivity in the z direction	0.05αx	default
θe	effective porosity	0.1	default

where u=Ki/θe

First-order Decay Coefficients

Chemical	Default Valueλ (d-1)	Required
Benzene	0.000127441	default
Toluene	0.0000208066	default
Ethylbenzene	0.0	default
Xylenes	0.0005	default
Naphthalene	0.00013	default
TEH-Diesel	0.0000554955	default
TEH-Waste Oil	0.0000554955	default

Other Parameters for Groundwater Vapor to Enclosed Space

Parameter		Default Value	Required
Lgw	depth to groundwater from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	200 cm	option
ER (s-1)	enclosed space air exchange rate	0.00014	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

Other Parameters for Soil Vapor to Enclosed Space

Parameter		Default Value	Required
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	250 cm *	option
ER (s-1)	enclosed space air exchange rate	0.000185 *	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

*These values are an average of residential and nonresidential factors.

Soil Leaching to Groundwater

Parameter		Default Value	Required
δ	groundwater mixing zone	2 m	default

Building Parameters for Iowa Tier 2

Parameter		Residential	Nonresidential
ER (s-1)	enclosed space air exchange rate	0.00014	0.00023
L_B	enclosed space volume/infiltration area ratio	200 cm	300 cm

Other Parameters

For Tier 2, the following are the same as Tier 1 values (refer to Appendix A): chemical-specific parameters, slope factors and reference doses, and exposure factors (except for those listed below).

Exposure Factors for Tier 2 Groundwater Vapor to Enclosed Space Modeling:

Potential Residential: use residential exposure and residential building parameters.

Potential Nonresidential: use nonresidential exposure and nonresidential building parameters.

Diesel and Waste Oil

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	150	0.012	0.12	1.2
		potential	150	1.2	12.0	NA
	Groundwater Vapor to Enclosed Space	all	4,440	NA	NA	NA
	Groundwater to Plastic Water Line	all	150	1.2	12.0	NA
	Surface Water	all	150	1.2	12.0	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	7.6	NA	NA	NA
	Soil Vapor to Enclosed Space	all	95	NA	NA	NA
	Soil to Plastic Water Line	all	21	NA	NA	NA

Due to difficulties with analytical methods for the four individual chemicals listed in the above table, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that diesel contains 0.2% napthalene, 0.001% benzo(a)pyrene, 0.001% benz(a)anthracene, and 0.001% chrysene. Resulting TEH Default Values are shown in the following table.

Diesel			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	75,000	1,200	12,000	120,000
		potential	75,000	120,000	1,200,000	NA
	Groundwater Vapor to Enclosed Space	all	2,200,000	NA	NA	NA
	Groundwater to Plastic Water Line	all	75,000	120,000	1,200,000	NA
	Surface Water	all	75,000	120,000	1,200,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	3,800	NA	NA	NA
	Soil Vapor to Enclosed Space	all	47,500	NA	NA	NA
	Soil to Plastic Water Line	all	10,500	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Due to difficulties with analytical methods for the four individual chemicals, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that waste oil contains no naphthalene, 0.003% benzo(a)pyrene, 0.003% benz(a)anthracene, and 0.003% chrysene. Resulting TEH Default Values are shown in the following table.

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	NA	400	4,000	40,000
		potential	NA	40,000	400,000	NA

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Vapor to Enclosed Space	all	NA	NA	NA	NA
	Groundwater to Plastic Water Line	all	NA	40,000	400,000	NA
	Surface Water	all	NA	40,000	400,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	NA	NA	NA	NA
	Soil Vapor to Enclosed Space	all	NA	NA	NA	NA
	Soil to Plastic Water Line	all	NA	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Appendix B-1 – Tier 2 Equations and Parameter Values (Old Model)

All Tier 1 equations and parameters apply at Tier 2 except as specified below.

Equation for Tier 2 Groundwater Contaminant Transport Model

$$C(x) = C_s \exp\left(\frac{x}{2\alpha_x}\left[1-\sqrt{1+\frac{4\lambda\alpha_x}{u}}\right]\right)\operatorname{erf}\left(\frac{S_w}{4\sqrt{\alpha_y x}}\right)\operatorname{erf}\left(\frac{S_d}{4\sqrt{\alpha_z x}}\right)$$

Variable definitions

x: distance in the x direction downgradient from the source
erf( ): the error function
C(x): chemical concentration in groundwater at x
C_s: Source concentration in groundwater (groundwater concentration at x=0)
S_w: width of the source (perpendicular to x)
S_d: vertical thickness of the source
u: groundwater velocity (pore water velocity); u=Ki/θe
K: hydraulic conductivity
i: groundwater head gradient
θe: effective porosity
λ: first-order decay coefficient, chemical specific
αx, αy, αz: dispersivities in the x, y and z directions, respectively

For the following lists of parameters, one of three is required: site-specific measurements, defaults or the option of either (which means the default may be used or replaced with a site-specific measurement).

Soil parameters

Parameter		Default Value	Required
ρ_s	soil bulk density	1.86 g/cm^3	option
f_{oc}	fraction organic carbon in the soil	0.01 kg-C/kg-soil	option
θ_T	total soil porosity	0.3cm^3-voids/cm^3-soil	option
θ_{as}	volumetric air content in vadose zone	0.2cm^3-air/cm^3-soil	default
θ_{ws}	volumetric water content in vadose zone	0.1cm^3-H_2O/cm^3-soil	default
θ_{acrack}	volumetric air content in foundation/wall cracks	0.2cm^3-air/cm^3-soil	default
θ_{wcrack}	volumetric water content in foundation/wall cracks	0.1cm^3-H_2O/cm^3-soil	default
I	infiltration rate of water through soil	7 cm/year	default

If the total porosity is measured, assume 1/3 is air filled and 2/3 is water filled for determining the water and air fraction in the vadose zone soil and floor cracks.

Groundwater Transport Modeling Parameters

Parameter		Default Value	Required
K	hydraulic conductivity	16060 cm/year	site-specific
i	groundwater head gradient	0.01 cm/cm	site-specific
S_w	width of the source	use procedure specified in 135.10(2)	site-specific
S_d	vertical thickness of the source	3 m	default
αx	dispersivity in the x direction	0.1x	default
αy	dispersivity in the y direction	$0.33\alpha x$	default
αz	dispersivity in the z direction	$0.05\alpha x$	default
θe	effective porosity	0.1	default

where $u=Ki/\theta e$

Groundwater Transport Modeling Parameters (continued)

First-order Decay Coefficients

Chemical	Default Value λ (d-1)	Required
Benzene	0.0005	default
Toluene	0.0007	default
Ethylbenzene	0.00013	default
Xylenes	0.0005	default
Naphthalene	0.00013	default
Benzo(a)pyrene	0	default
Benz(a)anthracene	0	default
Chrysene	0	default

Other Parameters for Groundwater Vapor to Enclosed Space

Parameter		Default Value	Required
Lgw	depth to groundwater from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	200 cm	option
ER (s-1)	enclosed space air exchange rate	0.00014	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

Other Parameters for Soil Vapor to Enclosed Space

Parameter		Default Value	Required
L_s	depth to subsurface soil sources from the enclosed space foundation	1 cm	option
L_B	enclosed space volume/infiltration area ratio	250 cm *	option
ER (s-1)	enclosed space air exchange rate	0.000185 *	default
Lcrack	enclosed space foundation or wall thickness	15 cm	default
η	areal fraction of cracks in foundation/wall	0.01	default

*These values are an average of residential and nonresidential factors.

Soil Leaching to Groundwater

Parameter		Default Value	Required
δ	groundwater mixing zone	2 m	default

Building Parameters for Iowa Tier 2

Parameter		Residential	Nonresidential
ER (s-1)	enclosed space air exchange rate	0.00014	0.00023
L_B	enclosed space volume/infiltration area ratio	200 cm	300 cm

Other Parameters

For Tier 2, the following are the same as Tier 1 values (refer to Appendix A): chemical-specific parameters, slope factors and reference doses, and exposure factors (except for those listed below).

Exposure Factors for Tier 2 Groundwater Vapor to Enclosed Space Modeling:

Potential Residential: use residential exposure and residential building parameters.

Potential Nonresidential: use nonresidential exposure and nonresidential building parameters.

Diesel and Waste Oil

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	150	0.012	0.12	1.2
		potential	150	1.2	12.0	NA
	Groundwater Vapor to Enclosed Space	all	4,440	NA	NA	NA
	Groundwater to Plastic Water Line	all	150	1.2	12.0	NA
	Surface Water	all	150	1.2	12.0	NA

Diesel and Waste Oil			Chemical-Specific Values for Tier 1			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Soil (mg/kg)	Soil Leaching to Groundwater	all	7.6	NA	NA	NA
	Soil Vapor to Enclosed Space	all	95	NA	NA	NA
	Soil to Plastic Water Line	all	21	NA	NA	NA

Due to difficulties with analytical methods for the four individual chemicals listed in the above table, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that diesel contains 0.2% napthalene, 0.001% benzo(a)pyrene, 0.001% benz(a)anthracene, and 0.001% chrysene. Resulting TEH Default Values are shown in the following table.

Diesel			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	75,000	1,200	12,000	120,000
		potential	75,000	120,000	1,200,000	NA
	Groundwater Vapor to Enclosed Space	all	2,200,000	NA	NA	NA
	Groundwater to Plastic Water Line	all	75,000	120,000	1,200,000	NA
	Surface Water	all	75,000	120,000	1,200,000	NA
Soil (mg/kg)	Soil Leaching to Groundwater	all	3,800	NA	NA	NA
	Soil Vapor to Enclosed Space	all	47,500	NA	NA	NA
	Soil to Plastic Water Line	all	10,500	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

Due to difficulties with analytical methods for the four individual chemicals, Total Extractable Hydrocarbon (TEH) default values were calculated for each chemical, using the assumption that waste oil contains no naphthalene, 0.003% benzo(a)pyrene, 0.003% benz(a)anthracene, and 0.003% chrysene. Resulting TEH Default Values are shown in the following table.

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Groundwater (ug/L)	Groundwater Ingestion	actual	NA	400	4,000	40,000
		potential	NA	40,000	400,000	NA
Groundwater (ug/L)	Groundwater Vapor to Enclosed Space	all	NA	NA	NA	NA
	Groundwater to Plastic Water Line	all	NA	40,000	400,000	NA
	Surface Water	all	NA	40,000	400,000	NA

Waste Oil			TEH Default Values			
Media	Exposure Pathway	Receptor	Naphthalene	Benzo(a) pyrene	Benz(a) anthracene	Chrysene
Soil (mg/kg)	Soil Leaching to Groundwater	all	NA	NA	NA	NA
	Soil Vapor to Enclosed Space	all	NA	NA	NA	NA
	Soil to Plastic Water Line	all	NA	NA	NA	NA

The lowest TEH default value for each pathway (shown as a shaded box) was used in the Tier 1 Table.

APPENDIX C
DECLARATION OF RESTRICTIVE COVENANTS
Rescinded IAB 7/19/06, effective 8/23/06

APPENDIX D
IOWA DEPARTMENT OF NATURAL RESOURCES

NO FURTHER ACTION CERTIFICATE

This document certifies that the referenced underground storage tank site has been classified by the Iowa Department of Natural Resources (IDNR) as "no action required" as provided in the 1995 Iowa Code Supplement 455B.474(1)"h"(1). This certificate may be recorded as provided by law.

ISSUED TO: OWNERS/OPERATORS OF TANKS
DATE OF ISSUANCE:
IDNR FILE REFERENCES: LUST # REGISTRATION #
LEGAL DESCRIPTION OF UNDERGROUND STORAGE TANK SITE:

Issuance of this certificate does not preclude the IDNR from requiring further corrective action due to new releases and is based on the information available to date. The department is precluded from requiring additional corrective action solely because governmental action standards are changed. See 1995 Iowa Code Supplement 455B.474(1)"h"(1).

This certificate does not constitute a warranty or a representation of any kind to any person as to the environmental condition, marketability or value of the above referenced property other than that certification required by 1995 Iowa Code Supplement 455B.474(1)"h".

These rules are intended to implement Iowa Code sections 455B.304, 455B.424 and 455B.474.

[Filed emergency 9/20/85—published 10/9/85, effective 9/20/85]
[Filed emergency 11/14/86—published 12/3/86, effective 12/3/86]
[Filed emergency 12/29/86—published 1/14/87, effective 1/14/87]
[Filed 5/1/87, Notice 1/14/87—published 5/20/87, effective 7/15/87][1]
[Filed emergency 9/22/87—published 10/21/87, effective 9/22/87]
[Filed 2/19/88, Notice 11/18/87—published 3/9/88, effective 4/13/88]
[Filed emergency 10/24/88—published 11/16/88, effective 10/24/88]
[Filed 7/21/89, Notice 2/22/89—published 8/9/89, effective 9/13/89]
[Filed emergency 8/25/89—published 9/20/89, effective 8/25/89]
[Filed 8/31/90, Notice 3/21/90—published 9/19/90, effective 10/24/90]
[Filed 2/1/91, Notice 11/14/90—published 2/20/91, effective 3/27/91]
[Filed emergency 3/29/91—published 4/17/91, effective 3/29/91]
[Filed emergency 8/28/91—published 9/18/91, effective 8/28/91]
[Filed emergency 2/21/92 after Notice 9/18/91—published 3/18/92, effective 2/21/92]
[Filed 9/24/93, Notice 3/17/93—published 10/13/93, effective 11/17/93]
[Filed 12/1/95, Notice 8/16/95—published 12/20/95, effective 1/24/96]
[Filed emergency 6/25/96—published 7/17/96, effective 8/15/96]
[Filed emergency 12/20/96 after Notice 7/17/96—published 1/15/97, effective 12/20/96]
[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]
[Filed 10/1/99, Notice 7/14/99—published 10/20/99, effective 11/24/99]
[Filed emergency 9/29/00—published 10/18/00, effective 9/29/00]
[Filed 1/19/01, Notice 10/18/00—published 2/7/01, effective 3/14/01]

[Filed 12/19/01, Notice 10/17/01—published 1/9/02, effective 2/13/02]
[Filed 3/23/06, Notice 11/9/05—published 4/12/06, effective 5/17/06]
[Filed 6/28/06, Notice 3/15/06—published 7/19/06, effective 8/23/06]
[Filed emergency 7/6/07—published 8/1/07, effective 7/6/07]
[Filed 10/4/07, Notice 8/1/07—published 10/24/07, effective 11/28/07]
[Filed 6/12/08, Notice 2/13/08—published 7/2/08, effective 8/6/08]

[1] Effective date of 135.9(4) delayed 70 days by Administrative Rules Review Committee at its June 1987 meeting.

CHAPTER 3
PHARMACY TECHNICIANS
[Prior to 9/4/02, see 657—Ch 22]

657—3.1(155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Board" means the Iowa board of pharmacy.

"Cashier" means a person whose duties within the pharmacy are limited to accessing finished, packaged prescription orders and processing payments for and delivering such orders to the patient or the patient's representative.

"Certified pharmacy technician" or *"certified technician"* means an individual who holds a valid current national certification and who has registered with the board as a certified pharmacy technician. The term includes an individual registered with the board who voluntarily acquired certification as provided in subrule 3.5(2).

"Delivery" means the transport and conveyance of a finished, securely packaged prescription order to the patient or the patient's caregiver.

"Nationally accredited program" means a program and examination for the certification of pharmacy technicians that is accredited by the NCCA.

"NCCA" means the National Commission for Certifying Agencies.

"Nuclear pharmacy technician" means a person who is employed in Iowa by a licensed nuclear pharmacy under the responsibility of an Iowa-licensed qualified nuclear pharmacist to assist in the technical functions of the practice of pharmacy pursuant to 657—Chapter 16.

"Pharmacy technician" or *"technician"* means a person who is employed in Iowa by a licensed pharmacy under the responsibility of an Iowa-licensed pharmacist to assist in the technical functions of the practice of pharmacy, as provided in rules 3.22(155A) through 3.24(155A).

"Pharmacy technician certification" or *"national certification"* means a certificate issued by a national pharmacy technician certification authority accredited by the NCCA attesting that the technician has successfully completed the requirements of the certification program. The term includes evidence of renewal of the national certification. "National certification," as that term relates to a nuclear pharmacy technician working exclusively in an Iowa-licensed nuclear pharmacy, shall be as defined in rule 657—16.2(155A).

"Pharmacy technician trainee" or *"technician trainee"* means an individual who is in training to become a pharmacy technician and who is in the process of acquiring national certification as a pharmacy technician as provided in rule 3.5(155A).

"Pharmacy technician training" or *"technician training"* means education or experience acquired for the purpose of qualifying for and preparing for national certification.

"Supervising pharmacist" means an Iowa-licensed pharmacist who is on duty in an Iowa-licensed pharmacy and who is responsible for the actions of a pharmacy technician or other supportive personnel.

"Supportive personnel" means a person, other than a licensed pharmacist, a registered pharmacist-intern, or a registered pharmacy technician, who may perform nontechnical duties assigned by the pharmacist under the pharmacist's supervision, including delivery, billing, cashier, and clerical functions.

657—3.2(155A) Purpose of registration. A registration program for pharmacy technicians is established for the purposes of determining the competency of a pharmacy technician or of an applicant for registration as a pharmacy technician, a certified technician, or a pharmacy technician trainee and for the purposes of identification, tracking, and disciplinary action for violations of federal or state pharmacy or drug laws or regulations.

657—3.3(155A) Registration required. Any person employed in Iowa as a pharmacy technician, except a pharmacist-intern whose pharmacist-intern registration is in good standing with the board, shall obtain and maintain during such employment a current registration as a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee pursuant to these rules. An individual accepting employment as a pharmacy technician or technician trainee in Iowa who fails to register as a pharmacy technician, certified technician, or technician trainee as provided by these rules may be subject to disciplinary sanctions.

3.3(1) *Licensed health care provider.* Except as provided in this rule, a licensed health care provider whose registration or license is in good standing with and not subject to current disciplinary sanctions or practice restrictions imposed by the licensee's professional licensing board and who assists in the technical functions of

the practice of pharmacy shall be required to register as a pharmacy technician, certified technician, or technician trainee pursuant to these rules.

3.3(2) *Original application required.* Any person not currently registered with the board as a pharmacy technician or certified technician shall complete an application for registration within 30 days of accepting employment in an Iowa pharmacy as a pharmacy technician. Such application shall be received in the board office before the expiration of this 30-day period.

3.3(3) *Technician training.* A person who is enrolled in a college-based or American Society of Health-System Pharmacists (ASHP)-accredited technician training program shall obtain a pharmacy technician trainee registration prior to beginning on-site practical experience. A person who is employed in a pharmacy and who is receiving pharmacy technician training through work experience shall obtain a pharmacy technician trainee registration within 30 days of the commencement of pharmacy technician training.

3.3(4) *Registration number.* Each pharmacy technician, certified technician, and technician trainee registered with the board will be assigned a unique registration number.

657—3.4 Reserved.

657—3.5(155A) Certification of pharmacy technicians. Prior to July 1, 2010, the certification and recertification of pharmacy technicians shall be voluntary and not mandatory. Beginning July 1, 2010, the certification of pharmacy technicians shall be required as provided by this rule. National certification does not supplant the need for licensed pharmacist control over the performance of delegated functions, nor does national certification exempt the pharmacy technician from registration pursuant to these rules.

3.5(1) *Voluntary certification prior to July 1, 2010.* An individual who holds a valid current national certification from the Institute for the Certification of Pharmacy Technicians (ICPT) or the Pharmacy Technician Certification Board (PTCB) and who acquired such certification prior to July 1, 2010, shall be deemed to have met the requirement for national certification beginning July 1, 2010, provided the certification is maintained in current standing.

3.5(2) *Required certification effective July 1, 2010.* Beginning July 1, 2010, a pharmacy technician shall acquire national certification through any NCCA-accredited pharmacy technician certification program and examination, the successful completion of which fulfills the requirement for national certification. National certification of a nuclear pharmacy technician employed solely in the practice of nuclear pharmacy shall be pursuant to certification requirements identified in 657—Chapter 16.

3.5(3) *Pharmacy technician trainee.* Beginning July 1, 2009, a person who is in the process of acquiring national certification as a pharmacy technician shall register with the board as a pharmacy technician trainee. The registration shall be issued for a period of one year and shall not be renewed.

3.5(4) *Certified pharmacy technician.* Beginning July 1, 2010, all applicants for a new pharmacy technician registration, except as provided by subrule 3.5(3), and all applicants for renewal of a pharmacy technician registration shall provide proof of current national pharmacy technician certification and shall complete the application for certified pharmacy technician registration.

657—3.6 and **3.7** Reserved.

657—3.8(155A) Application form.

3.8(1) *Required information.* The application for a pharmacy technician registration, certified technician registration, or pharmacy technician trainee registration shall include the following:

a. Information sufficient to identify the applicant including, but not limited to, name, address, date of birth, gender, and social security number;

b. Educational background;

c. Work experience;

d. Current place or places of employment;

e. Any other information deemed necessary by the board and as provided by this rule.

3.8(2) *Declaration of current impairment or limitations.* The applicant shall declare any current use of drugs, alcohol, or other chemical substances that in any way impairs or limits the applicant's ability to perform the duties of a pharmacy technician with reasonable skill and safety.

3.8(3) *History of felony or misdemeanor crimes.* The applicant shall declare any history of being charged, convicted, found guilty of, or entering a plea of guilty or no contest to a felony or misdemeanor crime (other than minor traffic violations with fines under $100).

3.8(4) *History of disciplinary actions.* The applicant shall declare any history of disciplinary actions or practice restrictions imposed by a state health care professional or technician licensure or registration authority.

3.8(5) *Additional information.* The following additional information shall be required from an applicant for the specified registration.

a. Technician trainee. The applicant for technician trainee registration shall identify the source of technician training, the anticipated date of completion of training, and the anticipated date of national certification.

b. Certified pharmacy technician. The applicant for certified technician registration shall provide proof of current pharmacy technician certification. The applicant shall also identify all current pharmacy employers including pharmacy name, license number, address, and average hours worked per week.

c. Licensed health care provider. In addition to the additional information required by paragraph *"a"* or *"b"* as applicable, a licensed health care provider shall provide evidence that the licensee's professional license or registration is current and in good standing and is not subject to current disciplinary sanctions or practice restrictions imposed by the licensee's professional licensing authority.

3.8(6) *Sworn signature.* The applicant shall sign the application under penalty of perjury and shall submit the application to the board with the appropriate fees pursuant to rule 3.10(155A).

657—3.9(155A) Registration term and renewal. Prior to July 1, 2008, a pharmacy technician registration shall expire on the second last day of the birth month following initial registration, with the exception that a new pharmacy technician registration issued within the two months immediately preceding the applicant's birth month shall expire on the third last day of the birth month following initial registration. A pharmacy technician registration issued between July 1, 2008, and July 1, 2009, except as provided in subrule 3.9(1), shall expire no later than June 30, 2010. Registration shall not require continuing education for renewal.

3.9(1) *Certified pharmacy technician registration.* A certified pharmacy technician registration shall expire on the second last day of the birth month following initial registration, with the exception that a new certified pharmacy technician registration issued within the two months immediately preceding the applicant's birth month shall expire on the third last day of the birth month following initial registration.

3.9(2) *Pharmacy technician trainee registration.* Beginning July 1, 2009, a registration for a pharmacy technician who is in the process of acquiring national certification (technician trainee) shall expire on the last day of the registration month 12 months following the date of registration or 12 months following the date registration was required pursuant to subrule 3.3(3).

a. National certification completed. When the registered technician trainee completes national certification, and no later than the date of expiration of the technician trainee registration, the pharmacy technician trainee shall complete and submit an application for certified pharmacy technician registration. A successful application shall result in issuance of a new certified pharmacy technician registration as provided in subrule 3.9(1).

b. Voluntary cancellation of registration. A registered technician trainee who fails to complete national certification prior to expiration of the technician trainee registration shall notify the board that the pharmacy technician trainee registration should be canceled and that the individual has ceased practice as a pharmacy technician.

c. Failure to notify the board. If a pharmacy technician trainee fails to notify the board prior to the expiration date of the technician trainee registration regarding the individual's intentions as provided in paragraph *"a"* or *"b,"* the technician trainee registration shall be canceled and the individual shall cease practice as a pharmacy technician.

657—3.10(155A) Registration fee. The following fees for initial registration and registration renewal shall apply to the specified registration applications filed within the following time frames. The appropriate fee shall be submitted with the registration application in the form of a personal check, certified check or cashier's check, or a money order payable to the Iowa Board of Pharmacy.

3.10(1) *Registration prior to July 1, 2009.* The fee for obtaining an initial technician registration, for obtaining an initial certified pharmacy technician registration, or for renewal of a technician or certified technician registration prior to July 1, 2009, shall be $40 plus applicable surcharge pursuant to rule 657—30.8(155A).

3.10(2) *Registration beginning July 1, 2009.* The fee for obtaining an initial certified pharmacy technician registration or for biennial renewal of a certified pharmacy technician registration beginning July 1, 2009, shall be $50 plus applicable surcharge pursuant to rule 657—30.8(155A).

3.10(3) *Technician trainee registration beginning July 1, 2009.* The fee for a one-year pharmacy technician trainee registration shall be $20 plus applicable surcharge pursuant to rule 657—30.8(155A).

657—3.11(155A) Late applications and fees.

3.11(1) *Initial registration.* An application for initial registration that is not received within the applicable period specified in subrule 3.3(2) or 3.3(3) shall be delinquent, and the applicant shall be assessed a late payment fee. The late payment fee shall be equal to the amount of the fee for initial registration. A delinquent initial registration shall include payment of the initial registration fee, applicable surcharge pursuant to rule 657—30.8(155A), and late payment fee.

3.11(2) *Registration renewal.* A technician registration that is not renewed before its expiration date shall be delinquent, and the registrant shall not continue employment as a pharmacy technician until the registration is reactivated. An individual who continues employment as a pharmacy technician without a current registration, in addition to the pharmacy and the pharmacist in charge that allow the individual to continue practice as a pharmacy technician, may be subject to disciplinary sanctions.

a. A person who is required to renew a registration pursuant to these rules and who fails to renew the registration before the first day of the month following expiration shall pay the renewal fee, a penalty fee equal to the amount of the renewal fee, plus the applicable surcharge pursuant to rule 657—30.8(155A).

b. A person who is required to renew a registration pursuant to these rules and who fails to renew the registration before the first day of the second month following expiration shall pay the renewal fee, a penalty fee equal to the amount of the renewal fee, the applicable surcharge pursuant to rule 657—30.8(155A), plus an additional penalty fee of $10 for each additional month, not to exceed three additional months, that the registration is delinquent. The maximum combined fee payment for reactivation of a delinquent registration shall not exceed an amount equal to twice the renewal fee plus $30 plus the applicable surcharge pursuant to rule 657—30.8(155A).

657—3.12(155A) Registration certificates. The certificate of technician registration issued by the board to a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee is the property of and shall be maintained by the registered technician. The certificate or a copy of the certificate shall be maintained in each pharmacy where the pharmacy technician, certified pharmacy technician, or pharmacy technician trainee works. Each pharmacy utilizing pharmacy technicians shall be responsible for verifying that all technicians, certified technicians, and technician trainees working in the pharmacy are registered, and that technician registrations remain current and active.

657—3.13(155A) Notifications to the board. A pharmacy technician, certified pharmacy technician, or technician trainee shall report to the board within ten days a change of the technician's name, address, or pharmacy employment status.

657—3.14 to **3.16** Reserved.

657—3.17(155A) Training and utilization of pharmacy technicians. All Iowa-licensed pharmacies utilizing pharmacy technicians shall develop, implement, and periodically review written policies and procedures for the training and utilization of pharmacy technicians appropriate to the practice of pharmacy. Pharmacy policies shall specify the frequency of review. Technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of technician training shall be available for inspection and copying by the board or an agent of the board.

657—3.18(147,155A) Identification of pharmacy technician.

3.18(1) *Identification badge.* A pharmacy technician shall wear a visible identification badge while on duty that clearly identifies the person as a pharmacy technician and that includes at least the technician's first name.

3.18(2) *Misrepresentation prohibited.* A pharmacy technician shall not represent himself or herself in any manner as a pharmacist or pharmacist-intern. A pharmacy technician shall not represent himself or herself in any manner as a certified pharmacy technician unless the technician has attained national pharmacy technician certification. A technician trainee shall not represent himself or herself in any manner as a certified pharmacy technician, as a pharmacist-intern, or as a pharmacist.

657—3.19 Reserved.

657—3.20(155A) Responsibility of supervising pharmacist. The ultimate responsibility for the actions of a pharmacy technician, a certified pharmacy technician, or a pharmacy technician trainee shall remain with the supervising pharmacist.

657—3.21(155A) Delegation of technical functions. A pharmacist may delegate technical dispensing functions to an appropriately trained and registered pharmacy technician, but only if the pharmacist is on site when delegated functions are performed, except as provided in 657—subrule 6.7(2) or 657—subrule 7.6(2), as appropriate, or as provided for telepharmacy in 657—Chapter 9. The pharmacist shall provide and document the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative.

657—3.22(155A) Technical functions. At the discretion of the supervising pharmacist, technical functions which may be delegated to a pharmacy technician, a certified pharmacy technician, or a pharmacy technician trainee include, but are not limited to, the following:

1. Performing packaging, manipulative, or repetitive tasks relating to the processing of a prescription or medication order in a licensed pharmacy.
2. Accepting prescription refill authorizations communicated to a pharmacy by a prescriber or by the prescriber's office.
3. Contacting prescribers to obtain prescription refill authorizations.
4. Collecting pertinent patient information.
5. Entering prescription and patient information into the pharmacy computer system.
6. Inspecting drug supplies provided and controlled by an Iowa-licensed pharmacy, including but not limited to drug supplies maintained in an ambulance or other emergency medical service vehicle, a long-term care facility, a hospital nursing unit, or a hospice facility.

657—3.23(155A) Tasks a pharmacy technician shall not perform. A pharmacy technician, a certified pharmacy technician, or a pharmacy technician trainee shall not:

1. Provide the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order;
2. Conduct prospective drug use review or evaluate a patient's medication record for purposes identified in rule 657—8.21(155A);
3. Provide patient counseling, consultation, or patient-specific drug information, tender an offer of patient counseling on behalf of a pharmacist, or accept a refusal of patient counseling from a patient or patient's agent;
4. Make decisions that require a pharmacist's professional judgment, such as interpreting prescription drug orders or applying information;
5. Transfer a prescription drug order to another pharmacy or receive the transfer of a prescription drug order from another pharmacy;
6. Delegate technical functions to supportive personnel.

657—3.24(155A) New prescription drug orders or medication orders. At the discretion of the supervising pharmacist, a pharmacy technician or a certified pharmacy technician may be allowed to accept new prescription drug orders or medication orders communicated to the pharmacy by a prescriber or by the prescriber's agent if the pharmacy technician or certified pharmacy technician has received appropriate training pursuant to the pharmacy's policies and procedures. The supervising pharmacist shall remain responsible for ensuring the accuracy, validity, and completeness of the information received by the pharmacy technician or certified technician. The pharmacist shall contact the prescriber to resolve any questions, inconsistencies, or other issues relating to the information received by the pharmacy technician or certified technician that involve a pharmacist's professional judgment.

657—3.25(155A) Delegation of nontechnical functions. A pharmacist may delegate nontechnical functions to supportive personnel only if the pharmacist is on site when delegated nontechnical functions are performed. A pharmacy technician shall not delegate technical functions to supportive personnel.

657—3.26 and **3.27** Reserved.

657—3.28(147,155A) Unethical conduct or practice. Violation by a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee of any of the provisions of this rule shall constitute unethical conduct or practice and may be grounds for disciplinary action as provided in rule 3.30(155A).

3.28(1) *Misrepresentative deeds.* A pharmacy technician, certified technician, or technician trainee shall not make any statement tending to deceive, misrepresent, or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

3.28(2) *Confidentiality.* In the absence of express written authorization from the patient or written order or direction of a court, except where the best interests of the patient require, a pharmacy technician, certified technician, or technician trainee shall not divulge or reveal to any person other than the patient or the patient's authorized representative, the prescriber or other licensed practitioner then caring for the patient, a licensed pharmacist, a person duly authorized by law to receive such information, or as otherwise provided in rule 657—8.16(124,155A), any of the following:

a. A patient's name, address, social security number, or any information that could be used to identify a patient;

b. The contents of any prescription drug order or medication order or the therapeutic effect thereof, or the nature of professional pharmaceutical services rendered to a patient;

c. The nature, extent, or degree of illness suffered by any patient; or

d. Any medical information furnished by the prescriber or the patient.

3.28(3) *Discrimination.* It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

3.28(4) *Unethical conduct or behavior.* A pharmacy technician, certified technician, or technician trainee shall not exhibit unethical behavior in connection with the technician's pharmacy employment. Unethical behavior shall include, but is not limited to, the following acts: verbal or physical abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

657—3.29(155A) Denial of registration. The executive director or designee may deny an application for registration as a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205 or any rule of the board.

An individual whose application for registration as a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee is denied pursuant to this rule may, within 30 days after issuance of the notice of denial, appeal to the board for reconsideration of the application.

657—3.30(155A) Discipline of pharmacy technicians.

3.30(1) *Violations.* The board may impose discipline for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs, or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205 or any rule of the board.

3.30(2) *Sanctions.* The board may impose the following disciplinary sanctions:

a. Revocation of a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee registration.

b. Suspension of a pharmacy technician, certified pharmacy technician, or pharmacy technician trainee registration until further order of the board or for a specified period.

c. Nonrenewal of a pharmacy technician or certified pharmacy technician registration.

d. Prohibition, permanently, until further order of the board, or for a specified period, from engaging in specified procedures, methods, or acts.

e. Probation.

f. The ordering of a physical or mental examination.

g. The imposition of civil penalties not to exceed $25,000.

h. Issuance of a citation and warning.

i. Such other sanctions allowed by law as may be appropriate.

These rules are intended to implement Iowa Code sections 147.72, 155A.23, 155A.33, and 155A.39 and Iowa Code Supplement sections 155A.6 and 155A.6A.

[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]
[Filed 4/24/98, Notice 3/11/98—published 5/20/98, effective 6/24/98]
[Filed 2/22/99, Notice 10/21/98—published 3/10/99, effective 4/14/99]
[Filed 9/8/99, Notice 6/2/99—published 10/6/99, effective 11/10/99]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 3/11/04, Notice 8/6/03—published 3/31/04, effective 5/5/04]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed 3/5/08, Notice 12/19/07—published 3/26/08, effective 4/30/08][1]
[Filed emergency 6/9/08—published 7/2/08, effective 7/9/08]

[1] April 30, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.

CHAPTER 18
CENTRALIZED PRESCRIPTION FILLING AND PROCESSING

657—18.1(155A) Purpose and scope. The purpose of this chapter is to provide standards for centralized prescription drug order filling or centralized prescription processing by a pharmacy. Any facility established for the purpose of filling or processing prescription drug orders on behalf of other pharmacies shall be licensed as a pharmacy and shall hold all necessary registrations. A hospital pharmacy may participate in centralized prescription filling only of prescription drug orders for noncontrolled substances pursuant to these rules. A hospital pharmacy may engage in centralized prescription processing pursuant to the requirements of rule 657—7.7(155A). Except as specifically identified in the rules, the requirements of these rules for centralized prescription filling or centralized prescription processing are in addition to the requirements of 657—Chapters 6, 7, and 8, and other rules of the board relating to services provided by pharmacies.

657—18.2(155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Central fill pharmacy" means a pharmacy contracting with an originating pharmacy, or having the same owner as an originating pharmacy, that provides centralized prescription drug order filling on behalf of the originating pharmacy pursuant to these rules.

"Centralized prescription drug order filling" or *"centralized filling"* means the filling of a prescription drug order by a pharmacy on behalf of another pharmacy. "Centralized filling" does not include the processing or dispensing of a prescription drug order but may include any of the following filling functions:

1. Receiving prescription drug orders from the originating pharmacy;
2. Interpreting or clarifying prescription drug orders;
3. Entering prescription drug order information into a pharmacy's prescription record system;
4. Selecting, counting, and placing the prescribed drug into an appropriate prescription container;
5. Affixing the prescription label, including any auxiliary labels, to the prescription container;
6. Obtaining refill and substitution authorizations;
7. Verifying all filling processes performed by the central fill pharmacy.

"Centralized prescription drug order processing" or *"centralized processing"* means the processing of a prescription drug order by a pharmacy on behalf of another pharmacy. "Centralized processing" does not include the filling or dispensing of a prescription drug order but may include any of the following processing functions:

1. Interpreting or clarifying prescription drug orders;
2. Entering prescription drug order information into a pharmacy's prescription record system;
3. Interpreting clinical data for prior authorization for dispensing;
4. Performing formulary-directed therapeutic interchange.

"Central processing pharmacy" means a pharmacy contracting with an originating pharmacy, or having the same owner as an originating pharmacy, that provides centralized prescription drug order processing on behalf of the originating pharmacy pursuant to these rules.

"DEA" means the U.S. Department of Justice, Drug Enforcement Administration.

"Dispense" means the delivery of a prescription drug or device to an ultimate user or the ultimate user's agent by or pursuant to the lawful order of a practitioner. "Dispense" includes:

1. Receiving the prescription drug order from the patient, the patient's agent, or the prescriber;
2. Delivering the filled prescription to the patient or the patient's agent;
3. Providing drug information concerning a patient's drug therapy;
4. Providing patient counseling;
5. Providing medication therapy management.

"Hospital" means a facility licensed pursuant to Iowa Code chapter 135B.

"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.

"Mail order pharmacy" means a pharmacy located within a United States jurisdiction whose primary business is to dispense a prescription drug or device pursuant to a valid prescription drug order and to deliver the drug or device to a patient, including a patient in this state, via the United States Postal Service, a common carrier, or a

delivery service. "Mail order pharmacy" includes a pharmacy that does business via the Internet or other electronic media.

"Medication therapy management" means the review of drug therapy regimens of a patient by a pharmacist for the purpose of evaluating and rendering advice to a practitioner, or for the purpose of evaluating and modifying the drug regimen in accordance with a collaborative drug therapy management protocol pursuant to rule 657—8.34(155A).

"Originating pharmacy" means a pharmacy that receives a prescription drug order from a patient, the patient's agent, or a prescriber, outsources prescription filling or processing functions to another pharmacy, and ultimately dispenses the prescription drug or device to the patient or the patient's agent.

657—18.3(155A) General requirements.

18.3(1) *Essential qualifications.* An originating pharmacy may outsource prescription drug filling to a central fill pharmacy or prescription drug order processing to a central processing pharmacy provided the pharmacies:

a. Have the same owner or have entered into a written contract or agreement that outlines the services to be provided and the responsibilities and accountabilities of each pharmacy in compliance with federal and state laws, rules, and regulations; and

b. Share a common electronic file or have appropriate technology to allow access to sufficient information necessary or required to perform the contracted functions.

18.3(2) *Legal compliance.* An originating pharmacy, a central fill pharmacy, and a central processing pharmacy shall comply with all provisions applicable to the pharmacy contained in federal and state laws, rules, and regulations to the extent applicable for the specific filling or processing activity and these rules, including but not limited to the following:

a. Each pharmacy located within Iowa shall maintain Iowa pharmacy licensure and, if the pharmacy dispenses controlled substances, the pharmacy shall maintain DEA and Iowa controlled substances registrations.

b. Each pharmacy located outside Iowa shall maintain Iowa nonresident pharmacy licensure in addition to the licensure requirements of the pharmacy's home state.

c. Each pharmacist providing centralized prescription drug order processing or filling functions as an employee or agent of a central processing or central fill pharmacy located within Iowa shall maintain active licensure to practice pharmacy in Iowa.

d. Pharmacies shall comply with Iowa board rules relating to the duties that must be performed by a pharmacist.

e. Pharmacies shall comply with Iowa requirements for supervision of pharmacy technicians.

18.3(3) *Originating pharmacy responsibility.* Except as specifically provided by this subrule, the originating pharmacy shall be responsible for all dispensing functions as the term "dispense" is defined in rule 18.2(155A). An originating pharmacy contracting only for centralized filling shall retain responsibility for all processing functions, and an originating pharmacy contracting only for centralized processing shall retain responsibility for all filling functions.

a. A mail order pharmacy engaged in the centralized filling of prescription drug orders may deliver a filled prescription directly to the patient and shall not be required to return the filled prescription to the originating pharmacy.

b. A central fill or a central processing pharmacy that shares a common central processing unit with the originating pharmacy may perform prospective drug use review (DUR) pursuant to rule 657—8.21(155A). Only a pharmacist shall perform the DUR; the review shall not be delegated to a pharmacy technician, registered nurse, or other pharmacy support person. The pharmacist performing the DUR shall document in the shared patient record all concerns, recommendations, observations, and comments resulting from that review. The pharmacist at the originating pharmacy shall utilize the DUR notes in counseling the patient pursuant to rule 657—6.14(155A).

18.3(4) *Central fill label requirements.* The label affixed to the prescription container filled by a central fill pharmacy on behalf of an originating pharmacy shall include the following:

a. A unique identifier indicating that the prescription was filled at the central fill pharmacy;

b. Serial number (a unique identification number of the prescription) as assigned by the originating pharmacy;

c. The name, address, and telephone number of the originating pharmacy;

d. The name of the patient or, if such drug is prescribed for an animal, the species of the animal and the name of its owner;

e. The name of the prescribing practitioner;

f. The date the prescription is filled by the central fill pharmacy;

g. The directions or instructions for use, including precautions to be observed;

h. Unless otherwise directed by the prescriber, the name, strength, and quantity of the drug dispensed.

(1) If a pharmacist selects an equivalent drug product for a brand name drug product prescribed by a practitioner, the prescription container label shall identify the generic drug and may identify the brand name drug for which the selection is made, such as "(generic name) Generic for (brand name product)".

(2) If a pharmacist selects a brand name drug product for a generic drug product prescribed by a practitioner, the prescription container label shall identify the brand name drug product dispensed and may identify the generic drug product ordered by the prescriber, such as "(brand name product) for (generic name)";

i. The initials or other unique identification of the pharmacist in the originating pharmacy who performed drug use review and transmitted the prescription drug order to the central fill pharmacy.

657—18.4 Reserved.

657—18.5(155A) Patient notification and authorization.

18.5(1) *Prior notification and authorization.* A pharmacy that outsources prescription drug order filling or prescription drug order processing to another pharmacy shall, prior to outsourcing a patient's prescription:

a. Notify the patient or the patient's agent that prescription filling or processing may be outsourced to another pharmacy.

b. Provide the name of the pharmacy that will be filling or processing the prescription or, if the pharmacy is part of a network of pharmacies under common ownership and any of the network pharmacies may fill or process the prescription, the patient shall be notified of this fact. Notification may be provided through a one-time written notice to the patient or patient's agent or through use of a sign prominently displayed in the originating pharmacy.

c. Following patient notification and prior to outsourcing, the originating pharmacy shall receive written authorization from the patient to outsource the filling or processing of a patient's prescription drug order. If a patient does not so authorize the originating pharmacy, the pharmacy shall not outsource the filling or processing of the patient's prescription drug orders.

d. If a patient provides the originating pharmacy with notification that the patient no longer authorizes the originating pharmacy to outsource the patient's prescription drug orders, the originating pharmacy shall discontinue outsourcing the filling or processing of the patient's prescription drug orders.

18.5(2) *Exception.* The provisions of this rule do not apply to a patient in a facility, such as a hospital or long-term care facility, where Iowa law requires that drugs be administered to the patient by a health care professional.

657—18.6 to **18.9** Reserved.

657—18.10(155A) Policy and procedures.

18.10(1) *Manual maintained.* A policy and procedure manual relating to centralized filling or centralized processing activities shall be maintained at all pharmacies involved in centralized filling or centralized processing and shall be available for inspection and copying by the board or an agent of the board.

18.10(2) *Manual contents.* The manual shall:

a. Outline the responsibilities of each of the pharmacies;

b. Include a list of the names, addresses, telephone numbers, and all license and registration numbers of the pharmacies involved in centralized filling or centralized processing;

c. Include evidence that all licenses and registrations have been verified to be current and in good standing, identifying the individual verifying license and registration status and the method used to verify status; and

d. Include, but not necessarily be limited to, policies and procedures for:

(1) Protecting the confidentiality and integrity of patient information;

(2) Protecting each patient's freedom of choice of pharmacy services;

(3) Maintaining appropriate records to identify the name, the initials or unique identification code, and the specific activities of each pharmacist or pharmacy technician who performed any centralized filling or centralized processing function;

(4) Complying with federal and state laws, rules, and regulations;

(5) Operating a continuous quality improvement program for pharmacy services designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems; and

(6) Reviewing, at least annually, the written policies and procedures and documenting that review.

657—18.11 to **18.14** Reserved.

657—18.15(155A) Records. Central fill or central processing pharmacies shall maintain appropriate records that identify, by prescription drug order, the name and initials or unique identification code of each pharmacist or pharmacy technician who performs a centralized filling or centralized processing function for a prescription drug order. Originating pharmacies shall maintain appropriate records that identify, by prescription drug order, the name and initials or unique identification code of the pharmacist who performed drug use review and the pharmacist who transmitted the prescription drug order to the central fill or central processing pharmacy. These records may be maintained separately by each pharmacy or in a common electronic file as long as the data processing system is capable of producing a printout that lists the functions performed by each pharmacy and pharmacist or technician and identifies the pharmacist or technician who performed each function.

These rules are intended to implement Iowa Code sections 124.301, 124.306, 124.308, 155A.13, and 155A.28.

[Filed 6/2/05, Notice 1/19/05—published 6/22/05, effective 7/27/05]
[Filed 3/6/08, Notice 12/19/07—published 3/26/08, effective 4/30/08][1]
[Filed emergency 6/9/08—published 7/2/08, effective 7/9/08]

[1] April 30, 2008, effective date of ARC 6671B delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.

PUBLIC SAFETY DEPARTMENT[661]

Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

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[Transferred from O.P.P., ch 5, See IAB 7/6/83]
[Prior to 4/20/88, see Public Safety Department[680] Ch 16]

661—16.1 to **16.500** Rescinded IAB 12/21/05, effective 4/1/06. See 661—Chapters 300 and 301.

661—16.501 to **16.609** Reserved.

PART 1—MODULAR FACTORY-BUILT STRUCTURES

661—16.610(103A) "Modular factory-built structures." Division VI, Part 1, contains the rules and regulations which are to apply to all factory-built structures which are not specifically included in Part 2 of this division.

16.610(1) *Authority to promulgate rules.* Provisions contained within all sections of Part 1 are authorized under Iowa Code section 103A.9.

16.610(2) *Scope and applicability.* The provisions contained within Part 1 shall apply to the following:

a. Plan evaluation, manufacture, inspection, and installation of "modular factory-built structures," of closed-type construction and of open-type construction for those manufacturers who have by option chosen to have their building component, assembly or system considered to be closed construction.

b. Approval by the commissioner or the commissioner's designated representative of an organization or person referred to as a third-party agent, or independent inspection agency.

c. All "modular factory-built structures" manufactured for installation in Iowa after February 1, 1973.

d. Every modular factory-built structure, building, building system, component, assembly or system manufactured for installation in Iowa on or after February 1, 1973, shall bear a seal issued by the commissioner which certifies that the unit complies with the code and that the certificates and approvals required by these rules have been submitted or obtained.

e. Every modular factory-built structure, building, building system, component, assembly, or system which was manufactured before February 1, 1973, and which is being installed in Iowa for the first time shall have a seal attached attesting that it complies with the code and that the certificates and approvals have been submitted to the commissioner.

f. Modular factory-built structures moved or relocated after the first installation in Iowa shall comply with the applicable codes and zoning restrictions of the jurisdiction into which it is being moved or relocated.

16.610(3) *Definitions.* Definitions in Division I of this code also apply to Division VI. These definitions also apply to all parts of Division 6. This subrule covers terms and definitions that are defined for purposes of clarification when used in Division VI.

"Building." A combination of materials, whether portable or fixed, to form a structure affording facilities or shelter for persons, animals or property. The word "building" includes any part of a building unless the context clearly requires a different meaning.

"Building component." Any part, subsystem, subassembly, or other system designed for use in, or as part of, a structure, including but not limited to: structural, electrical, mechanical, fire protection, or plumbing systems, and including such variations thereof as are specifically permitted by regulation, and which variations are submitted as part of the building system or amendment thereof.

"Certificate of compliance." A certification which is filed with the commissioner which indicates that the third-party agency has approved specific models or model groups of factory-built structures as meeting the state building code. (See 16.610(14)*"d"* and 16.610(17).)

"Closed construction." Is any structure, building, component, assembly or system manufactured in such a manner that all portions cannot be readily inspected at the installation site without disassembly, damage to, or destruction thereof.

"Code compliance certificate." Is the certificate prepared by an approved manufacturer and submitted by the manufacturer for each unit which is to be installed in Iowa and includes an Installation Certificate. (See subrules 16.610(19) and 16.610(20).)

"Component." Any part, material or appliance which is built in as an integral part of the factory-built structure during the manufacturing process, or any factory-built system, subsystem or assembly not approved as part of a unit, section, or module.

"Evaluation or inspection agency." Is an approved person or organization, private or public, determined by the commissioner to be qualified by reason of facilities, personnel, experience and demonstrated reliability and independence of judgment, to investigate, evaluate and approve factory-built structures or buildings, building components, building systems, and compliance assurance programs.

"Factory-built structure." Is any structure, building, component, assembly or system which is of closed construction and which is made or assembled in manufacturing facilities, on or off the building site, for installation or assembly and installation, on the building site. Factory-built structures may also mean, at the option of the manufacturer, any structure or building of open construction, made or assembled in manufacturing facilities away from the building site, for installation, or assembly and installation, on the building site. Factory-built structure also means "factory-built unit."

"Independence of judgment." Means not being affiliated with or influenced by or controlled by building manufacturers or producers, suppliers, or vendors of products or equipment used in factory-built structures or buildings and building components in any manner which is likely to affect their capacity to tender reports and findings objectively and without bias.

"Manufacturer's bill of sale" means any document, certificate, sales receipt, etc., signed by the manufacturer or importer that the modular factory-built structure described has been transferred to the person or dealer named. The document shall have attached a copy of the 3A section of the Code Compliance Certificate or shall contain at least the make, model year, manufacturer's serial number, Iowa model approval number and the code compliance seal number of the unit.

"Model or model groups." One or more manufacturer-designed modular homes which can constitute one model group.

"Modular." A general term to describe all factory-built structures which are not manufactured homes, manufactured home add-on units, or temporary field construction offices, as defined in Part 2, at 661—16.620(103A). Modular includes, but is not limited to, panelized units, components, sections and modules.

"Module." A unit or a section which is assembled in its final form and transported in such a manner.

"Open construction." Is any structure, building, component, assembly or system manufactured in such a manner that all portions can be readily inspected at the installation site without disassembly, damage to, or destruction thereof.

"Seal" or *"insignia."* A device or insignia issued to the manufacturer by the commissioner for affixing to a factory-built structure or system evidencing compliance with the code.

"Section." A division of a factory-built structure that must be combined with other sections to form a complete structure.

"Structure." That which is built or constructed, an edifice or building of any kind, or any piece of work artificially built up or composed of parts joined together in some definite manner except transmission or distribution equipment of public utilities. The word "structure" includes any part of a structure unless the context clearly requires a different meaning.

"Testing agency." An organization approved by the commissioner which:

1. Is qualified and equipped for the testing, observation, evaluation, or approval of building components, construction, materials, equipment, or systems as regulated by approved standards;
2. Is not under the jurisdiction, affiliation, influence, or control of any manufacturer or supplier of any industry;
3. Makes available a published report in which specific information is included certifying that the equipment and installations listed or labeled have been tested and found acceptable according to approved standards.

"Third-party agency." Is an approved person or organization, private or public, determined by the state building code commissioner to be qualified to act as an evaluation, inspection, testing, or listing agency, as defined in this section.

"Unit." A single factory-built structure approved by the state building code commissioner. Units may be combined to form a larger complex structure or may be a combination of sections.

16.610(4) *Administration.* This section covers the basic requirements for constructing modular structures and all of the administrative procedures under which the modular program functions including methods of certification approval and manufacturing requirements, inspection and installation.

16.610(5) *Modular construction requirements.* All factory-built structures not designated as a manufactured home, manufactured home add-on or a temporary field construction office shall be constructed to the requirements

in Division I, Part 4, Division II, Division III, Division IV, or the alternate method of construction as provided for in Division V, Division VII whenever applicable and Division VIII of the state building code.

16.610(6) *Modular installation requirements.* All factory-built structures designated as modular units shall be installed according to the manufacturer's approved installation drawings and any additional state-approved requirements. All approvals shall be part of the third-party certification agency approval for their respective manufacturer. In addition, all installations shall comply with local building codes for items not included as part of the state approval and local zoning requirements whenever applicable.

Modular installers shall obtain approval as required by rule 661—16.622(103A).

Modular installation seals shall be obtained and attached upon completion and the installation certificate shall be completed and filed as per subrule 16.610(20).

16.610(7) *Procedures for approval.* The method of third-party certification and approval shall be used. The manufacturer shall contract with third-party agencies for third-party approvals and notify the building code commissioner of the intent to manufacture units to be installed in Iowa and the name of the third party or parties to be used.

The third-party agency (or agencies) shall also notify the commissioner that they have entered into a contract to perform services with the manufacturer.

Third-party approvals are required for plan and design approval, plant facilities approval and a continuing inspection of units during manufacture.

The manufacturers shall submit plans to the third-party agency or agencies for review and approval. After the plans, the plant facilities, and an inspection procedure have been approved by the third-party agency or agencies the manufacturer shall submit a compliance certificate on the form supplied by the commissioner for each model or model group. The commissioner will assign an Iowa approval number for those models included in the approval.

At the time of production of units for installation in Iowa the manufacturer shall obtain from the commissioner Iowa insignia seals for manufacture and installation, to be attached to the units at the time of manufacture and installation, as well as code compliance and installation certificates.

16.610(8) *Requirements and procedures for obtaining third-party agency approval.*

a. The commissioner or the commissioner's designated representative shall be responsible for approving any person, state or organization who submits an application to the commissioner for approval and whose application is accompanied by written material evidencing that said agency is:

1. Capable of discharging without bias the responsibilities assigned by these regulations.
2. Not under the jurisdiction or control of any manufacturer or supplier of any industry.
3. Professionally competent with independence of judgment to perform the function for which commissioned.
4. Qualified to submit all findings regarding code compliance in a detailed report to the commissioner.
5. Willing to be inspected and reviewed by the commissioner for all phases of work.

b. The commissioner, in considering the information supplied with the application for approval, may limit the agencies' approval to particular types of factory-built structures, buildings, building systems, components, assemblies or systems.

c. Other states wishing to exercise application with this state in order to act in the capacity of an approved third-party agency, may do so provided that:

1. The state laws for issuing seals or insignia for code compliance are equally effective as those specified in this code.
2. The conditions in "1" are enforced in their state.
3. Other states agree to monitoring of this reciprocal agreement by representatives of this state assigned by the commissioner.
4. Violations of any condition as part of the reciprocal agreement may be deemed just cause for revocation or suspension of this agreement by the commissioner.

16.610(9) *Third-party agency responsibilities.*

a. Evidence of approval by the state must be on file at each manufacturing facility.

b. Notify the commissioner when they have contracted with a manufacturer to serve as their third-party agency.

c. Manufacturer plans and specifications must be approved by the third-party agency.

d. File of all plans and documents must be maintained at each manufacturing facility and in the third-party agency office.

e. Send a report to the commissioner stating that the plans and specifications are in compliance with the Iowa state building code.

1. Plans and specifications are not necessary for submittal with this report.
2. A list of approved models for each manufacturing facility.
3. Verify that all engineering documents have been signed by a registered engineer or architect.
4. Update the report as necessary.
5. Indicate approval of installation procedures for all of these structures as well as the personnel who will be doing the installation. However, installation of factory-built structures shall be, in addition to provisions of this code, in accordance with any local ordinances which apply. (That is, those construction processes which are not included as part of the state approval.)

f. Notify the manufacturer of plans and specifications approval including model numbers for use in preparing certificates of compliance.

g. Inspect manufacturing facilities and review or establish a quality control program and test procedure.

h. Notify the manufacturer of facilities approval for use in preparing certificates of compliance.

i. Prepare an inspection manual to be used by the third-party inspectors and the commissioner. This manual shall be on file at each manufacturing facility.

j. Report to the state outlining in-plant procedures and include a typical inspection checkoff sheet.

k. Notify the manufacturer when in-plant inspection program is in force for use in preparing certificates of compliance.

l. Report each quarter to the state for each manufacturer and submit information as follows:

1. Account for all Iowa seals used by each manufacturer during the quarter.
2. Manufacturer's serial number and model number.
3. Third-party seal number.
4. Iowa seal number.
5. The portion of the unit which was actually inspected during an in-plant inspection.

16.610(10) *Third-party agency documentation and plan verification.* The third-party agency will be responsible for the investigation, evaluation, review of test results, of plans and documents, and each revision thereto submitted to the agency by the manufacturer with which it has a contract for compliance with applicable requirements set forth in this code. Such a review shall include but not be limited to:

a. All documentations and plans shall indicate the manufacturer's name, office address, and manufacturing facility address.

b. Manufacturer's plans shall show all elements relating to specific systems on drawings properly identifiable.

c. Each plan which contains material requiring engineering evaluation shall bear the signature and seal of a registered architect or engineer.

d. The plans shall also indicate the method of evaluation and inspection for all required on-site testing of each system.

e. Plans shall designate all work to be performed on site, including all system connections, equipment and appliances and all work performed within the plant.

f. Space shall be provided on all sheets of plans near the title box for the approved stamp.

g. Individual system design or any structural design or method of construction and data shall be in accordance with the Iowa state building code. Plumbing, electrical, heating and mechanical systems constitute individual system designs.

h. Grade, quality, and identification of all materials shall be specified.

i. Design calculations and test reports shall be submitted when specified or required.

j. Plans shall be drawn to scale.

k. Plans shall indicate the location of the approved seal and data plate locations.

l. Copies of approved plans showing third-party agency approval shall be on file at each manufacturing facility or made readily available.

m. Review and approval of all installation procedures must conform to the following:

1. Crews performing installation which are under the jurisdiction of the unit manufacturer or the manufacturer's designee, are approved as competent by the authorized third-party agency.
2. Copies of the installation manual must be available during installation for use by the commissioner or the commissioner's representative or by the local building official.

16.610(11) *Third-party agency plant investigation for quality control.* All manufacturing facilities shall be inspected to the performance objectives as stated in the Iowa state building code. These include as follows:

a. Review of the manufacturer's quality control manuals or establishing a quality control procedure to ensure code compliance.

b. Implementation of inspection and test procedures which will control the quality of fabrication and workmanship.

c. Making a complete report to the commissioner that includes certification of all manufacturing procedures.

16.610(12) *Third-party agency in-plant inspections.* To ensure compliance with the approved specifications and plans and the Iowa state building code and in conjunction with monitoring each manufacturer's quality control program, every approved third-party agency shall:

a. Maintain a record of inspections and such records shall be reported to the commissioner every quarter and include the seal report.

b. Witness and verify all required testing in accordance with the quality control manual.

c. Certify that all seals are being attached as required and only after each unit meets the code requirements.

d. Prepare a detailed inspection manual that specifies the third-party agency procedures in making the required inspections and have this manual available for use by the commissioner or the commissioner's representative when periodic monitoring is performed.

e. One hundred percent inspection is not required, however some part of every unit is required to be inspected. A complete inspection of a typical structural, plumbing, heating and electrical system shall be made each visit to the manufacturing facility.

16.610(13) *Reapproval of third-party agencies.* Any agency approved by the commissioner or the commissioner's designated representative must file for reapproval annually. Such application for reapproval may be filed at any time from the forty-fifth day prior to the scheduled annual expiration date of the current approval. The applying third-party agency seeking reapproval shall completely and accurately furnish all pertinent information as is necessary to make current the information previously submitted to the commissioner or the commissioner's representative as part of its original application for approval and all subsequent applications for reapproval. The application for reapproval shall then become a permanent record of the department administering the provisions of the code. Should there be no change in the status of the applying agency from its original application for approval, an affidavit to that effect shall suffice for consideration of approval.

16.610(14) *Requirements and procedures for modular manufacturers.*

a. Every manufacturer shall be responsible for all corrective actions required and the contractual agreement that each has with the approved third-party agency shall not diminish this responsibility.

b. Every manufacturer shall notify the building code commissioner that the manufacturer's facility desires to construct units which are to be installed in the state of Iowa.

c. Every manufacturer shall contract with an approved third-party agency to perform all duties listed in 5.610(9), 5.610(10), 5.610(11), and 5.610(12). The commissioner will furnish a list of approved third-party agencies upon request.

d. Every manufacturer shall file certificates of compliance with the commissioner for each model or model group, after all third-party reviews are completed. Whenever additional models or changes are proposed, the manufacturer shall file additional certificates of compliance or request that additions be made to existing model lists.

e. Every manufacturer shall notify the commissioner in writing within 60 days after the effective date of this code, the current Iowa approval(s) number that the manufacturer has been assigned and the models which will be manufactured to these standards. Approvals which have not been reaffirmed within this 60-day period shall be considered to be canceled.

f. Every manufacturer shall purchase Iowa seals from the office of the commissioner in accordance with requirements of 5.610(22).

g. All units or sections shall have seals if manufactured after February 1, 1973, and if they are to be installed in Iowa. Regardless of manufactured date, all units being installed in Iowa for the first time shall have a seal attached.

h. Every manufacturer shall complete and furnish compliance certificates and installation certificates in accordance with the requirements of 16.610(19) and 16.610(20).

16.610(15) *Manufacturer's data plate for modular units.* The following information shall be placed directly or by reference on one or more permanent manufacturer's data plates in the vicinity of the electrical distribution panel box or in some other designated location that is readily accessible for inspection.

a. Manufacturer's name and address.

b. Serial number of the structure or unit.

c. Model designation and name of each of the manufacturers of major factory-installed appliances.

d. Wherever applicable, identification of permissible type of gas for appliance and direction for water and drain connections.

e. Name and date of the standards complied with in construction of this structure or unit.

f. The seal serial number.

g. Design loads and special conditions or limitations.

h. Date of manufacture.

i. Electrical ratings. Instructions and warnings on voltage, phase size and connections of units and grounding requirements.

16.610(16) *Changes and alterations to factory-built structures.*

a. Changes to approved plans, drawings or installation instructions proposed by the manufacturer or third-party agency are to be requested in writing and submitted to the building code commissioner. All work being performed in the manufacturing plant that is affected by these changes will not proceed until written approval is received from the commissioner. Where these changes do not affect code compliance, then approval is permitted when changes are authorized through the third-party agency and said changes are then incorporated into the design documents.

b. The commissioner shall notify the manufacturer and the third-party agency of all amendments, deletions or additions to the code provisions and the commissioner shall allow the manufacturer a reasonable time frame in which to submit a request for a change in plan approval, if required, in order to conform to the code change.

c. Basic changes in manufacturing facility locations, company name or address changes, and changes resulting in companies changing ownership or dissolving their business are all to be reported promptly to the commissioner, in writing, generally within a two-week period after said change was made. The manufacturer shall also notify the third-party agency of said changes.

d. Alterations to factory-built structures pursuant to the construction, plumbing, heat producing, electrical equipment or installation or fire safety in a unit after an Iowa seal has been affixed are all considered to be subject to the same requirements that exist for any structure within the local jurisdiction.

e. The following shall not constitute an alteration to a factory-built structure.

(1) Any repairs to approved component parts.

(2) Conversion of listed fuel-burning appliances in accordance with the terms of their listing.

(3) Adjustment and maintenance of equipment installed in the factory-built structure.

(4) Replacement of equipment in kind.

16.610(17) *Certificate of compliance.* The manufacturer shall provide the building code commissioner with a certificate of compliance for each model or model group of the approved modular design. This certification shall be on a copy of Form ISBC-3 and shall include the following:

a. Model or model group number which will appear on the data plate and compliance certificate.

b. The signature of an authorized representative of the manufacturer.

c. The name of the third-party agency certifying compliance with the code, for each of the three certifications.

d. Evidence of code compliance certified by the third-party agencies, for the specific model or model group being submitted.

e. The type of Iowa seal and prefix letters which will be attached to the modular structure.

16.610(18) *Limitations.* For all types of structures other than one- and two-family dwellings, there shall be, with the certificate of compliance, an attached statement which sets out the limitations of the structure based on site conditions, type of construction, area, and height limitations. A statement to the effect that the structure should not be used except where it meets these conditions will not be acceptable.

16.610(19) *Code compliance certificates.* Each manufacturer will be provided with a combination code compliance and installation certificate by the building code commissioner when seals are purchased as per subrule 16.610(22). The manufacturer shall complete this form and distribute it as follows:

a. Copy 1A is returned to:

State Building Code Bureau
Department of Public Safety
Wallace State Office Building
Des Moines, Iowa 50319

b. Copy 2A is retained for plant records and to be used to make additional copies if necessary. An additional copy shall accompany other shipping documents carried by the transporter and be available for inspection by any authorized official or department.

c. The remainder of the compliance certificate is forwarded to the dealer, distributor, or any other person who is to obtain a local building permit, or oversee installation.

16.610(20) *Installation certificates.* The installation certificate portion of the supplied combination certificate (see 16.610(19)) shall be partially completed by the manufacturer at the same time the code compliance certificate is prepared and made part of the documents shipped with the unit and completed by the local building official or the installer.

a. When a building permit is required, Forms 1B, 3A, and 3B are presented to the local building official at the time application is made for a permit. The building official shall sign Forms 1B and 3B and forward Form 1B to the commissioner at the address designated in this section.

b. When a building permit is not required, Forms 1B and 3B are signed by the installer and forwarded to the commissioner at the address designated in this section.

16.610(21) *Certification seals.* There shall be two seals attached to every factory-built structure which is installed in Iowa.

a. Every module, unit, section, or component shall have a state seal securely affixed at the manufacturing facility to show that the manufactured unit is in compliance with the code. When components and systems are included within a module, section or unit and have been approved by the third-party agency to be part of that module, section or unit, only one seal is required for the module, section, or unit. A series of panels which make up the final unit when assembled at the site, and where approved in that manner, require only one seal.

b. Every completed unit when installed at the final site shall have an installation seal attached to show that the installation is in compliance with the requirements of this code.

16.610(22) *Seal issuance.* The state seal shall be issued by the state building code commissioner upon application and after approval of the plans and manufacturing procedures have been certified by the third-party agency evidencing compliance with this code. Applications for seals shall be made to the commissioner on the supplied form and include the following:

a. Number of seals requested for each type of seal and the letter prefix when required.

b. Iowa model or system approval numbers and third-party agency or agencies included.

c. Reference to manufacturing procedures approval and third-party agency or agencies involved.

d. A statement by the applicant that consent is given for inspection and investigation by the state at all reasonable hours.

e. The seal fees.

16.610(23) *Seal types and prefixes.* When ordering seals the manufacturer shall indicate the number of each type of seal requested and the letter prefixes required. MOD type seals shall be attached to all modular units which are as constructed to provisions of Division VI, subrule 16.610(5). Prefix letters (A, B, C, D, etc.) shall be required on seals for all multiple-sectioned structures and the seal numbers shall be identical except for the prefix letters. Prefix letters are not required for single-unit structures.

16.610(24) *Seal placement on modular units.* Every seal shall be assigned and securely affixed to a specific section or unit. Assigned seals are not transferable and are void when not affixed as assigned and all such seals shall be returned to or may be confiscated by the commissioner. The seal shall remain the property of the commissioner in the event of violation of the conditions of approval. Every seal shall be placed and affixed to each section or unit in a readily visible location.

16.610(25) *Denial and repossession of seals.* Should investigation or inspection reveal that a manufacturer is not constructing modular units in accordance with the plans approved by the third-party agency, and such manufacturer, after having been served with a notice setting forth in what respect the provisions of these rules and the code have been violated, continues to manufacture units in violation of these rules and the code, applications for new seals shall be denied and the seals previously issued shall be confiscated. Upon satisfactory proof of compliance such manufacturer may resubmit an application for seals.

16.610(26) *Seal removal.* In the event that any unit bearing the seal is found to be in violation of the code, the commissioner may remove the seal (after furnishing the owner or the owner's agent with a written statement of such violations). No new seals shall be issued until proof of corrections has been submitted to the commissioner.

16.610(27) *Lost or damaged seals.* When or if a seal has been lost or damaged, the commissioner shall be notified immediately in writing by the manufacturer. The manufacturer shall identify the unit serial number, and when possible, the seal number.

a. All seals that are damaged shall be promptly returned to the commissioner.

b. Lost and damaged seals shall be replaced by the commissioner with a new seal upon payment of the seal fee as provided in this section.

16.610(28) *Return of seals.* When a manufacturer discontinues production of a unit carrying plan approval, the manufacturer shall within ten days advise the commissioner of the date of such discontinuance and either return all seals allocated for such discontinued unit or assign said seals to other approved units.

16.610(29) *Fees.*

a. Form of remittance. All remittances shall be:

1. In the form of checks or money orders.
2. Payable to: Treasurer, State of Iowa.
3. Addressed to:

State Building Code Bureau
Department of Public Safety
Wallace State Office Building
Des Moines, Iowa 50319

b. Seal fees.

1.	Modular code compliance seals	
	No prefix or "A" prefix	$30.00 per seal
	B,C,D,E, etc. prefixes	$10.00 per seal
	Replacements	$10.00 per seal
2.	Modular installation seals	$15.00 per seal
	Replacement seals	$ 7.50 per seal

c. Other fees. For all other services furnished by the commissioner which are not direct administrative duties of the commissioner's office, such as, but not limited to: obtaining consultants for review and evaluation of approval applications, or obtaining reviews from the national code writing organizations, a fee equal to the direct expense shall be charged.

16.610(30) *Local issuance of building permits.*

a. The issuance of building permits and occupancy permits shall be in accordance with local ordinances and Iowa Code sections 103A.19 and 103A.20.

b. Local building codes and regulations shall apply to all parts of any project which are not included in the state approval of either the manufactured structure or the installation procedure.

c. Nothing in these rules or the state building code exempts any factory-built structure from the requirements of local zoning or site condition requirements.

16.610(31) *Noncompliance to code provisions.* Any noncompliance or unauthorized deviation with the provisions of this code from the approved plans or production procedures shall be just cause for the revocation of the plan approval and the return of the seals.

661—16.611 to **16.619** Reserved.

PART 2—MANUFACTURED HOUSING

661—16.620(103A) Manufactured home construction. (Previously called mobile home.)

16.620(1) *Authority to promulgate rules.* Pursuant to Public Law 93-383, Section 604, of the National Manufactured Home Construction and Safety Act of 1974, specified in 42 U.S.C. 5403 and signed into law on August 22, 1974, the authority to promulgate rules and regulations in order to establish federal manufactured home construction standards and procedures of enforcement were established by Congress and subsequent provisions for their implementation were so granted to the United States Department of Housing and Urban Development (HUD). Title VI of this Act authorizes the secretary of HUD to promulgate the federal standards and to issue the rules and regulations to ensure adequate administration and enforcement of such standards.

16.620(2) *Scope and applicability.*

a. Provisions contained within Part 2 shall apply to all factory-built structures defined as a "manufactured home" in subrule 16.620(4) of Part 2. These regulations shall govern manufactured homes that enter the first stage of production on or after June 15, 1976, and manufactured homes that entered the first stage of production prior to June 15, 1976, to which HUD (Department of Housing and Urban Development) labels were affixed. These provisions supersede all local, state, or other governmental regulations for manufactured home standards and are applicable for every manufactured home unit newly manufactured and offered for sale in the United States and its governing territories. These provisions do not apply to the following:

(1) Factory-built structures which comply with the requirements of Division VI, Part 1 of the state building code.

(2) Manufactured homes manufactured for installation in the state of Iowa on or after February 1, 1973, and prior to June 15, 1976.

b. Construction of multifamily manufactured homes, manufactured home add-on units, and temporary field construction offices will be covered by the provisions of Division VI, Part 2, however, the administration and the enforcement of the rules and regulations will apply as specified in Division VI, Part 1 for modular structures. These units will not bear a seal issued by the Department of Housing and Urban Development, but will bear an Iowa seal and be governed by all seal provisions outlined accordingly in Division VI, Part 1.

16.620(3) *Manufacture of units prior to June 15, 1976.* Manufactured home units, add-on units, multifamily manufactured homes and temporary field construction offices that were manufactured for installation in Iowa prior to June 15, 1976, which established the effective date of the HUD standard, shall have been constructed to the standards of manufactured homes of the Iowa state building code which was in effect at the time of manufacture.

16.620(4) *Definitions and terms.* Terms and definitions for purposes of clarification when used in Part 2. (See also subrule 16.610(3).)

"Anchoring equipment." Straps, cables, turnbuckles, clamps, clips, and other fasteners including tensioning devices, which are used with ties to secure a manufactured home to ground anchors.

"Anchoring system." A combination of ties, anchoring equipment, and ground anchors that will, when properly designed and installed, resist overturning and lateral movement of the manufactured home from wind forces.

"Approved installer." Approval by the commissioner or the commissioner's designated representative of a person, dealer, agency or organization, qualified to inspect, or install ground anchoring and support systems for manufactured homes or other manufactured structures, who installs units, for others, at a site of occupancy by attaching support and anchoring systems, and is familiar with and has agreed to comply with these installation procedures.

"Certificate, installation." The certificate provided by the installer to both the commissioner and the owner which warrants that the installation system complies with these rules. When an installer installs only the support system or anchorage system, an installation certificate shall also be completed and copies distributed accordingly for each installation and with the applicable information completed on the certificate pertinent to that type of installation (see subrule 16.623(5)).

"DAPIA." A design inspection agency approved by HUD to perform in-plant design reviews on all drawings and specifications in order to provide compliance to the HUD standard for manufactured home construction.

"Diagonal tie (frame tie)." A tie intended primarily to resist horizontal or shear forces and which may secondarily resist vertical, uplift, and overturning forces.

"Ground anchor." Any device at the manufactured home site designed to transfer manufactured home anchoring loads to the ground.

"IPIA." A production inspection agency approved by HUD to perform the in-plant quality assurance inspection programs within manufactured home manufacturing facilities.

"Label or certification label." The approved form of certification by the manufacturer that is affixed to each transportable section of each manufactured home manufactured for sale to a purchaser in the United States or its governing territories.

"Main frame" (Chassis). The structural component on which is mounted the body of the manufactured home.

"Manufactured home." (Previously called mobile home.) A structure transportable in one or more sections which when erected on site measures 8 body feet or more in width and 40 body feet or more in length or when erected on site is 320 or more square feet in area, and which is built on a permanent chassis and designed to be used as a dwelling unit with or without a permanent foundation when connected to the required utilities and includes the plumbing, heating, air conditioning and electrical systems contained therein.

"Manufactured home add-on." A structure which is designed and produced and to be made an integral part of a manufactured home and will be considered part of the manufactured home, when attached thereto.

"Manufacturer's statement of origin" means a certification signed by the manufacturer or importer that the manufactured home described has been transferred to the person or dealer named and that the transfer is the first transfer of the manufactured home in ordinary trade and commerce. In addition to the information required by the Iowa Department of Transportation definition 761—subrule 421.1(2), the label number required by the federal regulations Section 3282.362(c)(2) 24 CFR Chapter XX shall be included. (This number is commonly known as the HUD number.) The terms "manufacturer's certificate," "importer's certificate," "MSO" and "MCO" shall be synonymous with the term "manufacturer's statement of origin."

"Multifamily manufactured home." Manufactured homes designed and manufactured with more than one living unit.

"Pier." That portion of the support system between the pier foundation and the manufactured home exclusive of caps and shims.

"Pier foundation (footing)." That portion of the support system that transmits loads directly to the soil, and shall be sized to support the loads shown herein.

"SAA." A state administrative agency approved by the Department of Housing and Urban Development to participate in the enforcement of all provisions to which a manufactured home is regulated under the HUD standard.

"Seal, installation." Is an insignia issued by the commissioner which is attached to a manufactured home by the installer to certify that the installation is in compliance with the requirements of the state building code.

"Stabilizing system (tie-down system)." A combination of the anchoring system and the support system when properly installed. Therefore, components of the anchoring and support systems such as piers, pier foundations, ties, anchoring equipment, anchors, or any other equipment which supports or secures the manufactured home to the ground, shall be defined as stabilizing devices. For the purposes of this code the definition of a stabilizing system and the definition of a tie-down system shall be one and the same.

"Support system." A combination of pier foundations, piers, caps, and shims that will, when properly installed, support the manufactured home.

"Temporary field construction office." A factory-built structure used at a construction site as an office facility by the personnel engaged in the construction of another structure or project. The intent of this structure is to remain on the job site only as long as necessary during the construction and then be removed before construction is completed.

"Tie." Strap, cable or securing device used to connect the manufactured home to ground anchors.

"Tie-down system (stabilizing system)." Means a ground support system and a ground anchoring system used in concert to provide anchoring and support for a manufactured home.

"Vertical tie (over-the-top)." A tie intended to resist the uplifting and overturning forces. This tie may continue over-the-top but if properly attached may only extend partway up each side.

16.620(5) *Administration.* This section covers the basic requirements for constructing manufactured homes and all of the administrative procedures under which the manufactured home program functions including information pursuant to certification, approval and manufacturing requirements. This section also applies to those structures defined in subrule 16.620(4) of Part 2 as manufactured home add-on units, temporary field construction offices and multifamily homes. There are also included within Part 2, (661—16.621(103A)) sections dealing with installation procedures and information pursuant to the handling of consumer complaints (16.620(15)) consistent with the duties of the state of Iowa to be performed as a State Administrative Agency (SAA) in conjunction with the manufactured home program.

16.620(6) *Manufactured home construction requirements.* All factory-built structures that are defined as a manufactured home under subrule 16.620(4) of Part 2, shall be constructed to the standards as promulgated by

the United States Department of Housing and Urban Development hereafter referred to as HUD. These standards were published as final rules in the December 18, 1975, issue of the Federal Register, Volume 40, No. 244, and will be amended from time to time. These standards are herein adopted and apply to all manufactured homes manufactured after June 15, 1976. All provisions for manufactured home procedural and enforcement regulations are covered within the May 13, 1976, Federal Register, Volume 41, No. 94. All factory-built structures defined as a manufactured home by the federal standard shall be manufactured and so regulated by these documents.

16.620(7) *Procedures of approval for manufactured homes.* Every manufactured home unit or structure approval will follow the method of third-party certification approval with all approvals obtained through the HUD secretary. All manufactured home plans, specifications, documentation, plant facilities and in-plant inspections must be submitted to and approved by a third-party certification agency so designated by the HUD secretary. Rules and regulations pursuant to these procedures are outlined in the manufactured home procedural and enforcement regulations, Parts 3282.201 through 3282.204 which set out requirements to be met by states or private organizations which wish to qualify as primary inspection agencies (see subrule 16.620(4) of Part 2 definitions for IPIA and DAPIA).

16.620(8) *Compliance certification.* Every manufactured home unit or structure must conform to the certification requirements within section 3282.205 of the manufactured home procedural enforcement regulatory document.

16.620(9) *Certification seals (labels) and other seal requirements.* Every manufactured home unit or structure must conform to the requirements within the manufactured home procedural and enforcement regulatory document section 3282.362(c)(2) in lieu of Iowa insignias. Other types of units manufactured under the requirements of Division VI, Part 2, will be labeled as prescribed in subrules 16.620(10), 16.620(11) and 16.620(12).

16.620(10) *Manufactured home add-on units.* Every factory-built structure manufactured as a manufactured home add-on unit as defined in subrule 16.620(4) of Part 2 shall be constructed to the standards set forth in subrule 16.620(6) of Part 2 except that these units will bear an Iowa seal in accordance with the provisions of the Iowa state building code, Division VI, Part 1. Manufacturers of manufactured home add-on units with the exception of constructing to the HUD standard, which has been herein adopted for these units, must comply with all other provisions of the Iowa state building code as described within Division VI, Part 1, for the factory-built structures.

16.620(11) *Multifamily homes.* Every factory-built structure manufactured as a multifamily home within the definition contained in subrule 16.620(4) of Part 2 shall be constructed to the standards set forth in subrule 16.620(6) of Part 2 except that these units will bear an Iowa seal in accordance with the provisions of the Iowa state building code, Division VI, Part 1. Manufacturers of multifamily homes, with the exception of constructing units to the HUD standard which has herein been adopted for these units, must comply with all other provisions of the Iowa state building code as described within Division VI, Part 1, factory-built structures.

16.620(12) *Temporary field construction offices.* Every factory-built structure manufactured as a temporary field construction office within the definition as contained in subrule 16.620(4) of Part 2 shall be constructed to the standards set forth in subrule 16.620(6) of Part 2 except that these units will bear an Iowa seal in accordance with the provisions of the Iowa state building code, Division VI, Part 1. Manufacturers of temporary field construction offices, with the exception of constructing units to the HUD standard which has herein been adopted for these units, must comply with all other provisions of the Iowa state building code as described within Division VI, Part 1, factory-built structures.

16.620(13) *Seal types for manufactured home add-on units, temporary field construction offices and multifamily homes.* When ordering seals for manufactured home add-on units, temporary field construction offices or multifamily manufactured homes, each manufacturer will indicate the number of each type of seal requested and the letter prefix required. Examples of seals issued are as follows: (A00-0000MH), (B00-0000MH), C, D, and E, etc. Single units are without prefix letters (00-0000MH). For more details, see Division VI, Part 1, subrule 16.610(21).

It is noted that manufactured home type seals shall be attached to all of these type units. All other procedures for seal issuance, removal, damage, repossession and return are to conform with provisions of this code as outlined in Division VI, Part 1.

16.620(14) *Noncompliance.* Failure to conform to the provisions of Part 2 as they apply to the federal standard for the construction of manufactured homes is subject to the penalties where applicable as set forth within Division VI, Part 1. The state of Iowa having adopted the federal standard and the enforcement regulations shall participate

in the federal program as an agent of HUD thereby providing assurances to ensure code compliance when these units are offered for sale for subsequent installation within the state of Iowa.

16.620(15) *Consumer complaints.* The state building code bureau serving as an approved State Administrative Agency (SAA) for the Federal Department of Housing and Urban Development shall receive complaints and process them in accordance with the requirements of the federal regulations as outlined in subpart I, paragraph 3282.401, entitled, "Consumer Complaint Handling and Remedial Actions of the Manufactured Home Procedural and Enforcement Document." These specific complaints are categorized as possible imminent safety hazards or possible failures to conform to the federal standard. Imminent safety hazards shall be those items that could result in an unreasonable risk of injury or death to the occupants of the manufactured homes. Failures to conform to the federal standard are those items that do not result in an unreasonable risk of injury or death to the occupants of manufactured homes, but nevertheless do not meet the provisions of the federal standard in some specific manner.

661—16.621(103A) Installation of manufactured homes.

16.621(1) *Authority.* These rules and regulations are to establish minimum requirements for the installation of manufactured homes as authorized by Iowa Code section 103A.7, subsection 3, section 103A.9, and sections 103A.30 to 103A.33.

16.621(2) *Application.*

a. These rules apply to the initial installation of manufactured homes manufactured on or after February 1, 1973, and to factory-built structures manufactured homes before February 1, 1973, which have never been installed in Iowa, and are approved by the commissioner.

b. These rules apply to all manufactured homes, new or used, which are sold in Iowa or sold to be installed in Iowa after September 1, 1977, for new manufactured homes and January 1, 1978, for used manufactured homes. The seller shall provide an approved tie-down system and the purchaser shall install or have the system installed within 150 days (see subrule 16.620(4) for the definition of a tie-down system). The 150-day period is designated for time to complete the installation when climatic conditions may restrict the completion of the tie-down system.

c. These rules apply to the installation of manufactured home add-on units, temporary field construction offices and manufactured multifamily homes.

d. These rules shall apply to any person doing any work on any part of the tie-down system (both support or anchorage systems) whether the unit is being sold or not.

16.621(3) *Enforcement.* The commissioner shall administer and enforce these provisions. Any person, agent, or organization approved and authorized by the commissioner may inspect any installation system and equipment to ensure compliance with these regulations. Evidence of compliance shall be supported by the submission to the commissioner of a certificate of installation. One copy of such certificate will remain in possession of the owner of the installed structure.

16.621(4) *Manufactured home installation instructions.* Every manufactured home manufacturer which manufactures manufactured homes for installation in Iowa shall provide the commissioner with a reproducible copy of printed instructions of installation for each specific make and model of manufactured home which is to be installed in Iowa. These instructions shall include copies of the materials which have been certified by a registered professional engineer for compliance with the federal manufactured home construction standards and 3280.306(a)(2), 3280.306(b), and 3280.303(c) of the regulatory standards. The manufacturer's installation instructions shall also be available at the installation site.

16.621(5) *Approvals and procedures.* Requirements for approval of installers, support and anchorage systems, seals and certificates are described in the remaining sections of this part.

661—16.622(103A) Certification of manufactured home installers. Rescinded IAB 7/2/08, effective 7/1/08.

661—16.623(103A) Installation seal and certificate procedures for manufactured homes.

16.623(1) *Application for seals.* Any installer who has met the applicable requirements of 661—Chapter 374 may apply for installation seals as needed. Such seals may be obtained from the commissioner or local building officials or building department who is a participant in the state's installation program.

16.623(2) *Manufactured home installation certificates.* The installer of manufactured homes shall supply the building code commissioner and the owner of the unit with the signed and completed installation certificate which has been issued by the Iowa building code commissioner, within 30 days of affixing the Iowa installation seal.

16.623(3) *Obtaining installation certificates.* Any person who installs a tie-down system or any portion thereof shall be supplied with the installation certificate forms when ordering installation seals and the payment of the appropriate fee.

a. Installers who are not listed as an installer shall be supplied the proper form to be attached to the copy of the installation certificate to be filed with the commissioner, which will record compliance with the approved system.

b. Reserved.

16.623(4) *Placement of installation seal.* The installation seal shall be placed in a readily visible location on the rear of the unit. Those units manufactured after June 15, 1976, shall have the installation seal placed adjacent to the federal (HUD) label. Those units manufactured before June 15, 1976, shall have the installation seal placed at the left rear corner above any skirting.

Multiple width units require only one seal for the completed installation. Additions which are added after the initial installation shall have an installation seal on that portion.

16.623(5) *Denial and repossession of installation seals.* Should investigation or inspection reveal that an approved installer has not installed an anchoring system, support system, or the complete tie-down system according to these rules and the code, the commissioner may deny such installer's application for new installation seals and any installation seals previously issued shall be confiscated. Upon satisfactory proof of modification of such installation bringing them into compliance, such dealer or installer may resubmit an application for installation seals.

16.623(6) *Seal removal, installation.* Should a violation of the rules regarding installation be found, the commissioner may remove the installation seal after furnishing the owner or a designated agent with a written statement of such violation. The commissioner shall not issue a new installation seal until corrections have been made and the owner or a designated agent has requested an inspection pursuant to 16.625(1).

16.623(7) *Lost or damaged seals, installation.* When an installation seal is lost or damaged, the commissioner shall be notified in writing. Damaged or lost installation seals shall be replaced by the commissioner upon payment of the replacement installation seal fee as provided in rule 661—322.20(103A).

16.623(8) *Return of seals, installation.* When a dealer or installer discontinues the installation of manufactured homes, the dealer or installer shall notify the commissioner within ten days of the date of such discontinuance and return all unused installation seals which have been issued to the dealer or installer. Installation seals may not be transferred by any dealer or installer after being issued to that dealer or installer.

16.623(9) *Seals for existing manufactured homes.* Seals may be obtained for existing manufactured homes that are tied down in accordance with the requirements of rule 661—16.627(103A).

661—16.624 Reserved.

661—16.625(103A) Inspections and fee structure. Rescinded IAB 7/2/08, effective 7/1/08.

661—16.626(103A) Support and anchorage of manufactured homes. Rescinded IAB 7/2/08, effective 7/1/08.

661—16.627(103A) Approval of existing manufactured home tie-down systems. This rule is to provide a method by which manufactured homes which have been installed prior to August 12, 1983, can be sold without requiring a new tie-down system to be installed and to allow existing manufactured homes which are properly supported and anchored to be sold without installing new support and anchorage systems.

16.627(1) *Sale of a certified unit.*

a. The commissioner shall be notified in writing by the seller of the change of ownership when any manufactured home sold after August 12, 1983, remains in the same location. The installation seal shall remain in place and a copy of the installation certificate shall be supplied to the new owner. Replacement seals and certificates may be obtained if necessary (see subrule 16.623(9)).

b. A certified manufactured home sold after August 12, 1983, which is moved to a new location must obtain a new certificate and seal. However, the existing support and anchorage system may be used if the installer verifies the conditions of use and the installation procedures of the existing systems are met at the new location.

16.627(2) *Sale or acceptance of installed existing units as an owner's option.* Application may be made to the commissioner for approval of an existing manufactured home support and anchor system on one of the following conditions:

a. If the support and anchorage systems were installed by an approved installer and are approved systems.

b. If the existing support and anchorage system has been inspected by an approved installer and the installer attests by signing the installation certificate that to the best of the installer's knowledge, the existing systems are equal to or better than the minimum requirements of this code.

c. If the existing support and anchorage systems are inspected and approved by a registered engineer or architect, and attested to in writing.

d. If the existing support and anchorage systems are inspected by a field inspector with the Iowa state building code and the existing systems are found to be equal to or better than the minimum requirements of this code.

If compliance is met by one of the above procedures and payment of the required fee has been paid, an Iowa installation seal and certificate may then be issued.

661—16.628(103A) Procedure for governmental subdivisions for installation of factory-built structures. Any governmental subdivision which has adopted the state building code or any other building code is required to enforce the state building code requirements for the installation of factory-built structures (see Iowa Code section 103A.9(7)).

Governmental subdivisions who are issuing building permits and are inspecting construction for compliance with the local building regulations shall verify the installation of factory-built structures within their jurisdiction and shall sign the installation certificate and forward the appropriate copy to the commissioner.

1. The local official shall obtain the installation certificate and the installation seal from the person making application for a building permit which includes a factory-built structure.
2. Upon completion and review of the installation the local official shall attach the installation seal to the unit.
3. Governmental subdivisions are permitted to assess fees as may be required by local ordinances.
4. Nothing in this rule is intended to reduce the authority of the governmental subdivision from establishing zoning regulations as outlined in Iowa Code sections 414.28 and 335.30.

661—16.629(103A) Support and anchoring systems submission.

16.629(1) *Submission by manufacturer.* The manufacturer of each manufactured home installed in Iowa shall submit to the building code commissioner a copy of the installation instructions by mail in printed form and in an electronic form acceptable to the commissioner.

16.629(2) *Submission by licensed professional engineer.* A licensed professional engineer who designs a support and anchoring system for use in the installation of a manufactured home in Iowa shall submit to the building code commissioner a copy of the specifications and instructions for the system by mail in printed form and in an electronic form acceptable to the building code commissioner. A support and anchoring system designed by a licensed professional engineer shall not be utilized unless it has been submitted to the building code commissioner in compliance with this subrule.

TABLE 6A

MINIMUM NUMBER OF TIEDOWNS

REQUIRED FOR SINGLEWIDE MOBILE HOMES

MOBILE HOME BOX LENGTH NOT EXCEEDING	MINIMUM NUMBER OF TIEDOWNS PER SIDE	
	DIAGONAL TIES	VERTICAL TIES*
40′-0″	3	2
54′-0″	3	2
73′-0″	4	2
84′-0″	5	2

*If more than minimum number of vertical or diagonal ties have been supplied, they shall all be used.

NOTES:

1. Doublewide mobile homes shall comply with Table 6A except that no vertical ties are required.

2. Wherever a vertical tie and a diagonal tie lie in a plane which is vertical and transverse to the main longitudinal beam, both ties may be connected to the same ground anchor, providing that particular anchor withstands both loadings.

3. This table shall be used only if there are no manufacturers approved installation requirements.

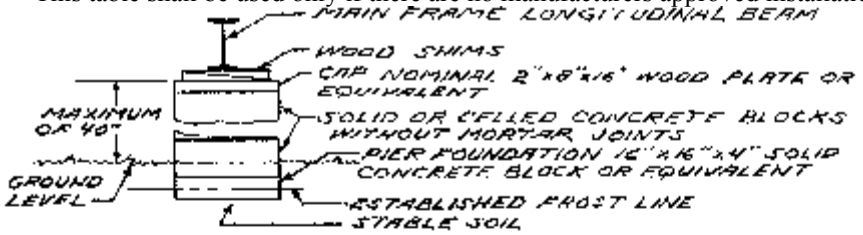


FIGURE 1. PIERS UP TO 40" IN HEIGHT (SINGLE BLOCK CONSTRUCTION)

NOTE: CORNER PIERS MORE THAN THREE (3) BLOCKS HIGH SHALL BE DOUBLE BLOCK CONSTRUCTION AS SHOWN IN FIGURES 2 & 3

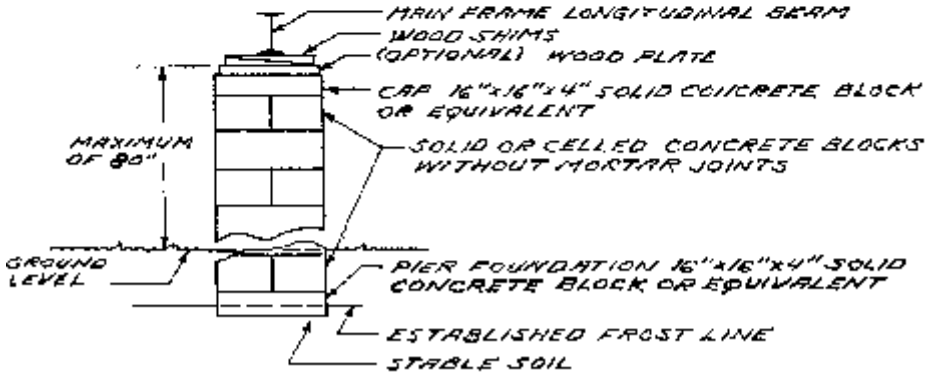


FIGURE 2 - PIERS OVER 40" IN HEIGHT AND NOT EXCEEDING 80" IN HEIGHT (DOUBLE BLOCK CONSTRUCTION)

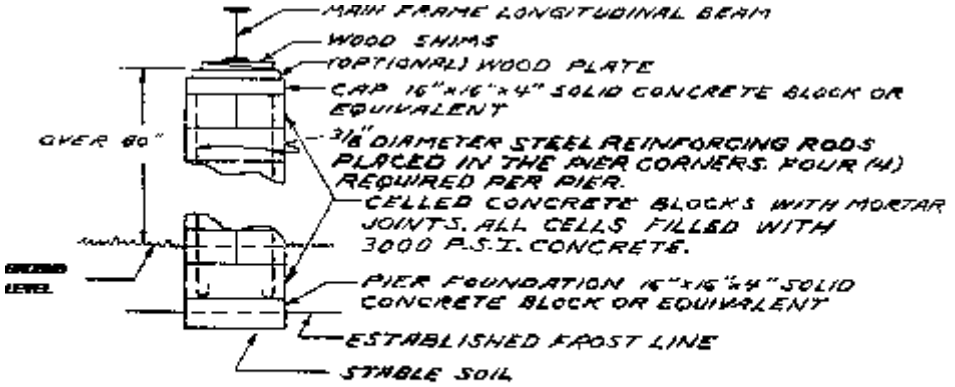
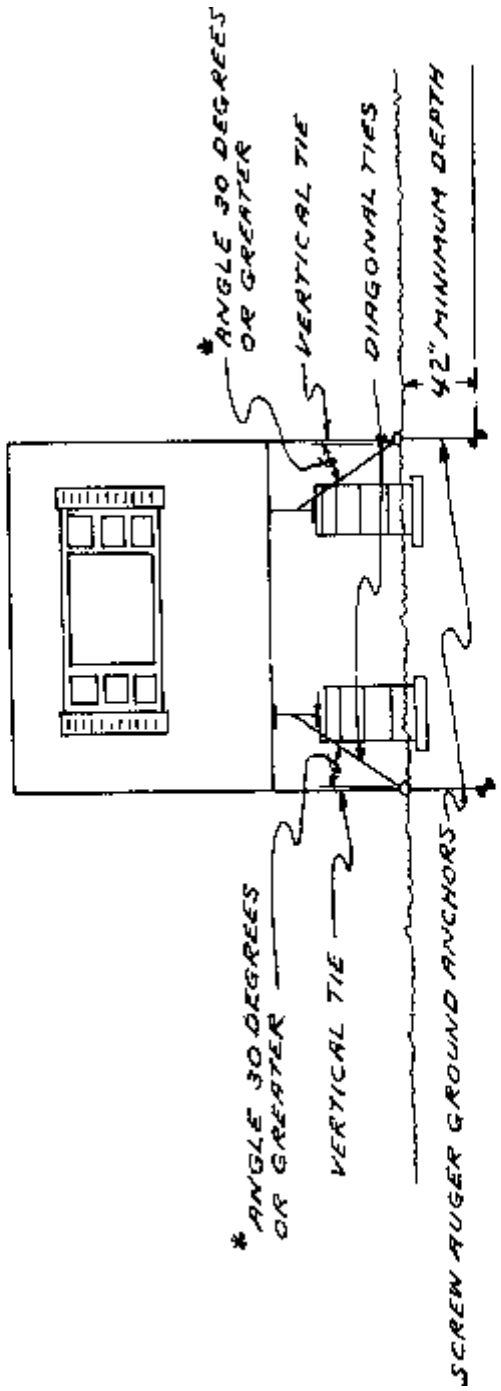


FIGURE 3 - PIERS OVER 80" IN HEIGHT (DOUBLE BLOCK CONSTRUCTION, STEEL REINFORCED)

FIGURE 4

MOBILE HOME TIEDOWN

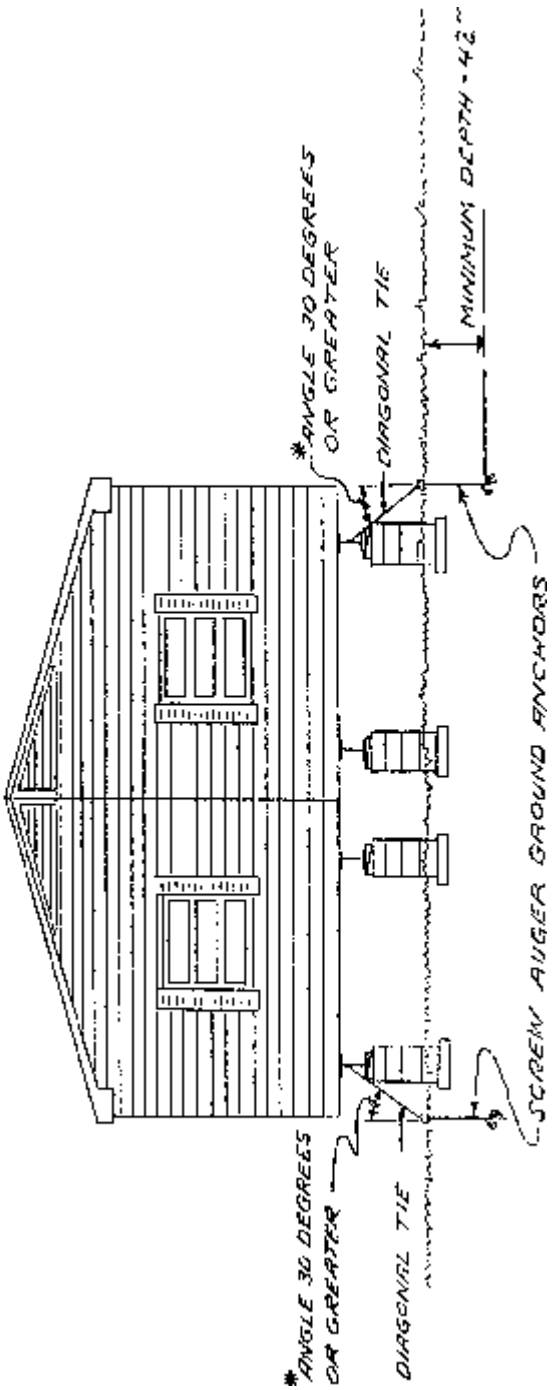


*DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.

FIGURE 5

DOUBLE WIDE MOBILE HOME TIEDOWN

*DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.



661—16.630 to **16.699** Reserved.

661—16.700 to **16.720** Rescinded IAB 12/21/05, effective 4/1/06. See 661—Chapter 302.

661—16.721 to **16.799** Reserved.

661—16.800 to **16.802** Rescinded IAB 12/21/05, effective 4/1/06. See 661—Chapter 303.

These rules are intended to implement Iowa Code section 103A.7 and Public Law 102-486.

[Filed and effective 7/15/75]
[Filed 7/7/77, Notice 4/20/77—published 7/27/77, effective 9/1/77]
[Filed 11/14/77, Notice 9/21/77—published 11/30/77, effective 1/4/78]
[Filed emergency 12/13/77—published 12/28/77, effective 1/4/78]
[Filed 9/27/78, Notice 3/22/78—published 10/18/78, effective 11/22/78]
[Filed emergency after Notice 2/6/79—published 3/7/79, effective 2/6/79, Notice 11/1/78][1]
[Filed 12/15/80, Notice 6/25/80—published 1/7/81, effective 3/1/81][2]
[Filed 10/30/81, Notice 9/2/81—published 11/25/81, effective 1/1/82]
[Filed 6/16/83, Notice 4/13/83—published 7/6/83, effective 8/12/83]
[Filed 8/10/84, Notice 5/23/84—published 8/29/84, effective 10/3/84]
[Filed 10/17/86, Notice 7/16/86—published 11/5/86, effective 1/1/87]
[Filed 12/23/86, Notice 7/16/86—published 1/14/87, effective 2/19/87]
[Filed 8/31/87, Notice 6/3/87—published 9/23/87, effective 11/1/87]
[Filed 4/1/88, Notice 9/23/87—published 4/20/88, effective 5/25/88]
[Filed 10/25/88, Notice 9/7/88—published 11/16/88, effective 1/1/89][3]
[Filed emergency 7/21/89—published 8/9/89, effective 7/21/89]
[Filed 10/13/89, Notice 8/9/89—published 11/1/89, effective 12/6/89]
[Filed 12/22/89, Notice 10/18/89—published 1/10/90, effective 2/14/90]
[Filed emergency 1/17/90—published 2/7/90, effective 2/14/90]
[Filed emergency 12/21/90—published 1/9/91, effective 1/1/91]
[Filed 3/29/91, Notice 11/28/90—published 4/17/91, effective 6/1/91]
[Filed 5/10/91, Notice 4/3/91—published 5/29/91, effective 7/3/91]
[Filed 8/28/92, Notice 5/27/92—published 9/16/92, effective 11/1/92]
[Filed 2/12/93, Notice 10/14/92—published 3/3/93, effective 5/1/93]
[Filed 9/23/94, Notice 7/6/94—published 10/12/94, effective 11/16/94]
[Filed 5/16/97, Notice 11/20/96—published 6/4/97, effective 7/15/97]
[Filed 11/26/97, Notice 10/22/97—published 12/17/97, effective 2/1/98]
[Filed 11/9/00, Notice 7/26/00—published 11/29/00, effective 1/3/01]
[Filed 11/9/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]
[Filed emergency 3/23/01—published 4/18/01, effective 4/1/01]
[Filed emergency 9/27/01—published 10/17/01, effective 10/1/01]
[Filed 6/13/03, Notice 11/27/02—published 7/9/03, effective 1/1/04]
[Filed emergency 1/30/04—published 2/18/04, effective 2/1/04]
[Filed 4/9/04, Notice 2/18/04—published 4/28/04, effective 6/2/04]
[Filed emergency 11/24/04—published 12/22/04, effective 12/1/04]
[Filed emergency 3/25/05—published 4/13/05, effective 4/1/05]
[Filed 12/2/05, Notice 9/14/05—published 12/21/05, effective 4/1/06]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

1 Inadvertently dropped out from 1/7/81 IAC Supplement replacement pages.

2 Effective date of IAB amendments to [O.P.P. 5.600 to 5.629] Division VI (16.600 to 16.629) delayed 70 days by the Administrative Rules Review Committee.

3 Effective date (1/1/89) of 16.120(2)[3802 "h" only] delayed until adjournment of the 1988 Session of the General Assembly by the Administrative Rules Review Committee at its December 13, 1988, meeting.
NOTE: Subrule 16.110(1) revised 7/30/97 in accordance with agency directive.

CHAPTER 17
CRIME VICTIM REPARATION

[Prior to 4/20/88, see Public Safety Department[680] Ch 17]

Program transferred to the Department of Justice—Attorney General[61] Ch 9, IAB 9/20/89. See 1989 Iowa Acts, House File 700.

CHAPTER 141
CLOSED CIRCUIT SURVEILLANCE SYSTEMS

[Prior to 6/8/05, see 661—Ch 23]

661—141.1(99F) Definitions. The following definitions apply to rules in 661—Chapter 141:

"Administrator" means the administrator of the Iowa racing and gaming commission.

"Applicant" means any person applying for an occupational license or applying for a license to operate an excursion gambling boat, or the officers and members of the board of directors of a qualified sponsoring organization located in Iowa.

[1] *"Casino"* means all areas of an excursion gambling boat, racetrack enclosure, or gambling structure licensed to conduct gambling games.

"Casino surveillance" means the observation of gaming and gaming-related activities in a licensed gaming establishment. The purpose of a surveillance system is to safeguard the licensee's assets, to protect both the public and the licensee's employees, and to promote public confidence that licensed gaming is conducted honestly and free of criminal elements and activities. It is the responsibility of the licensee to ensure that the surveillance system is used to accomplish the stated purposes and is not used in an improper manner that would bring discredit to the industry.

[1] *"Closed network"* or *"closed circuit"* means all digital recording equipment and all other associated surveillance equipment must be designed, configured, and maintained on a separate and exclusive network system located on the same premises as the casino. This closed network system must not be touched by, connected to, or partitioned off of any other network, except with approval of the DCI.

"Commission" means the Iowa racing and gaming commission.

"DCI" means the division of criminal investigation, Iowa department of public safety.

"Dedicated coverage" means camera coverage where the sole function is to view and record a specific area whenever activity is occurring in that area.

"Gambling game" means any game of chance authorized by the commission.

"Gangplank" means the walkways that passengers use to embark and disembark from the excursion gambling boat.

"Land-based facility" means the licensee's operation where the soft count room is located, if other than on an excursion gambling boat.

"Licensee" means a qualified sponsoring organization conducting gambling games on an excursion gambling boat or in a racetrack enclosure licensed by the Iowa racing and gaming commission under Iowa Code section 99F.7.

"Operator" means an entity licensed by the Iowa racing and gaming commission to operate an excursion gambling boat or racetrack enclosure.

"Slot change booth" means a structure on the floor of a licensed gaming establishment which houses a coin-counting device that is utilized to redeem coins or tickets from patrons.

[1] April 1, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held March 7, 2008. At its meeting held June 9, 2008, the Committee delayed the effective date until the adjournment of the 2009 Session of the General Assembly.

661—141.2(99F) Minimum standards. This chapter sets forth the minimum standards that must be followed by a licensee with respect to casino surveillance systems. The director of the DCI or the administrator may, at the director's or administrator's absolute discretion, require a licensee to comply with casino surveillance system requirements that are more stringent than those set forth by these rules.

NOTE: The requirements established in this chapter apply to casinos on excursion gambling boats pursuant to Iowa Code section 99F.4 and to casinos in other gaming establishments pursuant to 491—subrule 5.4(7).

661—141.3(99F) Surveillance departments—organizational structure. Surveillance departments are to be operated in an autonomous fashion, as separate and distinct entities from all other departments. A gaming facility's organizational structure shall place the director of the surveillance department directly under the span of control and authority of the operator's board of directors or appropriate parent company executive where practical. Under no circumstances will the director of surveillance report to or take direction from any authority at a level below the general manager.

661—141.4(99F) Closed circuit surveillance system.

[1]**141.4(1)** Every licensee shall install, maintain and operate, on the same premises where the casino is located or, with the approval of the DCI, on a property adjacent to the casino, a closed circuit surveillance system according to specifications set forth in these rules and shall provide to the commission and the DCI access at all times to the system or its signal.

141.4(2) Any casino issued a license on or after July 1, 2004, will be required to install a recording system that is totally digital and that meets the requirements as outlined in this chapter.

[1]**141.4(3)** All licensees shall have in place digital recording systems that meet the requirements of this chapter no later than January 1, 2011. Any system converted to digital prior to January 1, 2011, must meet the requirements of this chapter upon installation.

[1] April 1, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held March 7, 2008. At its meeting held June 9, 2008, the Committee delayed the effective date until the adjournment of the 2009 Session of the General Assembly.

661—141.5(99F) Required equipment. The closed circuit surveillance system shall include, but shall not be limited to, the following equipment:

141.5(1) *Cameras.* The system shall include Pan Tilt Zoom cameras, commonly referred to as PTZ cameras, that are light-sensitive and capable of being placed behind a dome or one-way mirror which conceals the PTZ cameras from view. Each camera shall have the capability to distinguish a clear, unobstructed view of the table number of the gaming table or slot machine.

141.5(2) *Printers.*

a. Video systems. The printers for video systems shall be capable of adjustment and must possess the capability to generate instantaneously upon command a clear, still copy of the image depicted on a videotape recording with a minimum of 128 shades of gray.

b. Digital systems. The printers for digital systems shall be capable of printing a clear, still copy using a minimum of four colors at 600 × 600 dots per inch on photo-quality paper.

141.5(3) *Monitors.* Each screen must be at least 12 inches measured diagonally and all controls must be front-mounted. Solid state circuitry is required.

141.5(4) *Date and time generators.* Each system shall be capable of synchronized recording in military time, with both the time and date of the recorded events displayed without obstructing the recorded view.

141.5(5) *Universal power supply.* The system and its equipment must be directly and securely wired in a way to prevent tampering with the system. In the event of a loss in power to the surveillance system, an auxiliary or backup power source must be available and capable of providing immediate restoration of power to the elements of the surveillance system that enable surveillance personnel to observe the gaming activity remaining open for play and all areas monitored by dedicated coverage.

141.5(6) *Domes for cameras.* The domes shall be made of sufficient quality and size to accommodate PTZ cameras and shall be capable of accommodating clear, unobstructed views.

141.5(7) *Switchers.* The switchers shall be capable of both manual and automatic sequential switching for the entire surveillance system.

141.5(8) *Recorders.* Each camera required by these standards must possess the capability of having its view displayed on a video or computer monitor and recorded. The surveillance system must include enough monitors and recording capacity to simultaneously display and record multiple gaming, cage, drop, count room activities, and record the views of all dedicated coverage. Recording systems shall be capable of copying original images while maintaining the original native format, and storing images in a format that contains a method to verify the authenticity of the original recordings and copies. The licensee shall supply the medium for download and transfer of the information and a jewel case or sleeve for the medium.

141.5(9) *Digital systems.*

a. All images and audio shall be digitally recorded and stored on a system with backup and retrieval capabilities.

b. Recording systems shall be locked by the manufacturer to disable the erase and reformat functions and to prevent access to the system data files.

c. The system shall provide uninterrupted recording while the playback or copy function is used.

[1]*d.* If the licensee chooses to use a network for the digital recording equipment, it must be a closed network with limited access located on the same premises as the casino, or, with the approval of the DCI, on a

property adjacent to the casino. The licensee must submit, for approval by the DCI, written policies governing the administration of the network, which shall include, but not be limited to, employee access levels and the transmission or release of live or recorded images, video, or audio. Nothing in this paragraph shall be interpreted to prevent the commission from utilizing or transmitting for regulatory purposes images recorded by a video surveillance system.

e. The licensee shall provide the DCI and the commission representative with the necessary software and hardware to review a downloaded recording. Additionally, the licensee shall provide the DCI and the commission representative with printers meeting the requirements as outlined in 661—subrule 141.5(2).

f. The licensee shall be responsible for staffing the surveillance room with licensed staff trained in the use of digital equipment. Surveillance employees shall be capable of downloading or copying digital audio or images, or both, for evidentiary purposes.

[1] April 1, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held March 7, 2008. At its meeting held June 9, 2008, the Committee delayed the effective date until the adjournment of the 2009 Session of the General Assembly.

661—141.6(99F) Required surveillance. Every licensee or operator shall conduct and record, as required by either the commission or the DCI, surveillance that allows clear, unobstructed views in the following areas of the gaming floor and related areas, land-based facilities, and racetrack enclosures:

141.6(1) *Slot machines.* Every licensee who exposes slot machines for play shall install, maintain, and operate a casino surveillance system that possesses the capability to monitor and record the slot machine number.

141.6(2) *Table games.* The surveillance system must possess the capability to monitor and record all gaming or card table surfaces; table number, including table bank trays, with sufficient clarity to permit identification of all chips, cash, card values, and the outcome of the game; dice in craps games, with sufficient clarity to read the dice in their stopped position after each roll; and all roulette tables and wheels must be capable of being monitored and recorded on a split screen to permit views of both the table and the wheel on one monitor screen. Each table or card game shall have the capability of being monitored and recorded by no less than two cameras.

141.6(3) *Progressive table games.* Each progressive table game must be monitored by dedicated coverage that provides views of the table surface so that the card values and card suits can be identified and a view of the progressive meter jackpot amount.

141.6(4) *Casino cage, slot change booth, and self-service coin, token, or ticket redemption center.* The surveillance system must possess the capability to monitor and record a general overview of activities occurring in each casino cage, slot change booth, and self-service coin, token, or ticket redemption center with sufficient clarity to identify patrons and employees at the counter area, cash drawers, vaults, safes, countertops, coin and currency counting machines, and chip and token storage, and to identify chip, token, and currency denominations. The casino cage and slot change booth area in which fills, credits, and jackpots are transacted must be monitored by dedicated coverage that provides views with sufficient clarity to identify the chip, token, and currency values and the amounts on the fill/credit slips.

141.6(5) *Count rooms.* The surveillance system must possess the capability to monitor and record all areas within the hard or soft count room, including walls, doors, scales, wrapping machines, coin sorters, currency counters, vaults, safes, and general work surfaces, whenever funds or persons are present. The counting surface in the soft count room must be made of a transparent material. Any area where uncounted coin or currency is stored must be monitored by dedicated coverage. In addition, the hard count and soft count process must be monitored by dedicated coverage.

141.6(6) *Movement of funds.* The surveillance system must possess the capability to monitor and record the movement of cash, gaming chips, tokens, drop boxes and drop buckets. All casino entrance and exit doors, elevators, stairs, gangplanks, and loading and unloading areas shall also possess the capability to be monitored and recorded if they are utilized for the movement of uncounted moneys, tokens, or chips.

141.6(7) *Admissions entrance and exits.* The admissions and exit areas of the excursion gambling boat and racetrack enclosures must be monitored by dedicated coverage with sufficient clarity to identify patrons and employees at the admissions entrance and exit areas.

141.6(8) *Overall views.* The surveillance system must possess the capability to monitor and record the casino pit area and general casino floor with sufficient clarity to permit identification of players, employees, patrons, and spectators.

141.6(9) *Additional coverage.* The DCI may require surveillance coverage of any other operation or game either on an excursion gambling boat, at a land-based facility, or at a racetrack enclosure.

141.6(10) *Digital systems.* All areas that require dedicated coverage and all images viewed on a surveillance operator's working monitor shall be recorded at a sufficient rate of images per second so that, when played back in real time, there is no motion loss detectable to the human eye.

661—141.7(99F) Equipment in DCI offices. Excursion gambling boat, racetrack enclosure or land-based offices assigned to the DCI shall be equipped with at least two video or computer monitors, each a minimum of 12 inches, with control capability of any source in the surveillance system. The following shall be additional mandatory equipment for said room or rooms:

1. A printer meeting the specifications of 661—subrule 141.5(2).
2. Two recorders.
3. Audio pickup of soft count room.
4. Time and date generators, if not in the master surveillance system.
5. Total override surveillance system capabilities.

661—141.8(99F) Camera lenses. All closed circuit cameras shall be equipped with lenses of sufficient quality to show clearly the value of gaming chips, tokens, and playing cards. These cameras shall be capable, at a minimum, of black and white recording and viewing, except those cameras covering exits and entrances of the casino area and gangplank areas, which shall be capable of recording in color.

661—141.9(99F) Lighting. Adequate lighting shall be present in all areas of the casino and count rooms to enable the video surveillance system to provide clear viewing and reproductions.

[1]**661—141.10(99F) Surveillance room.** There shall be provided in each gambling facility or gambling structure a room specifically utilized to monitor and record activities on the casino floor, count room, cashier cages, gangplank areas, admission entrances and exits, and slot change booths. This room shall have a trained surveillance person present at all times during casino operation hours. In addition, a gambling structure, excursion gambling boat or racetrack enclosure may have satellite monitoring equipment. The following are requirements for the operation of equipment in the surveillance room and of satellite monitoring equipment:

[1]**141.10(1)** *Surveillance equipment location.* All equipment that may be utilized to monitor or record views obtained by a casino surveillance system must remain in a room located on the same premises as the casino, or, with the approval of the DCI, on property adjacent to the casino and must be used exclusively for casino surveillance security purposes. The satellite monitoring equipment must be capable of being disabled from the casino surveillance room when not in use. The entrance to the casino surveillance room must be locked or secured at all times.

141.10(2) *Override capability.* Casino surveillance equipment must have total override capability over any other satellite monitoring equipment in other casino offices, with the exception of the DCI rooms.

141.10(3) *Access.* DCI and commission employees shall at all times be provided immediate access to the casino surveillance room and satellite monitoring equipment. Also, all DCI and commission employees shall have access to all records and areas of such rooms.

141.10(4) *Surveillance logs.* Entries in the log shall be required when specific surveillance is requested by the DCI or the commission, or whenever any activity that appears unusual, irregular, illegal or in violation of commission rules is observed. Also, all communications received or sent from the surveillance room in regard to surveillance activities or casino operations shall be logged.

141.10(5) *Blueprints.* A copy of the configuration of the casino floor shall be posted and updated immediately upon any approved change. The location of any change and the location of surveillance cameras, gaming tables and slot machines by assigned numbers shall also be included. Copies of the blueprints shall be made available immediately to the DCI and commission.

141.10(6) *Storage and retrieval.* Surveillance personnel shall label and file all recordings. The date and time of the recording shall be recorded. Recordings of admission entrances, exits, and casino cashier cages where check-cashing activities occur shall be retained for 21 days unless a longer period is required by the DCI, the commission, or court order. All other recordings shall be retained for at least 7 days after recording unless a longer period is required by the DCI, the commission, or court order. Original audio, video, and digital recordings shall be released to the DCI or commission upon demand.

141.10(7) *Malfunctions.* Each malfunction of surveillance equipment must be repaired within 24 hours of the malfunction. If, after 24 hours, activity in the affected area cannot be monitored, the game or machine shall be closed until such coverage can be provided. A record of all malfunctions shall be kept and reported to the DCI each day. In the event of a dedicated coverage malfunction, the licensee must immediately provide alternative camera coverage or other security measures that will protect the subject activity. If other security measures are taken, the licensee must immediately notify the DCI. The DCI, in its discretion, will determine whether the other security measures are adequate.

141.10(8) *Security.* Entry to the surveillance room and access to satellite monitoring equipment shall be limited to persons approved by the DCI or the commission. A log of personnel entering and exiting the surveillance room and accessing satellite monitoring equipment shall be maintained and submitted to the DCI or the commission upon request.

141.10(9) *Playback station.* Within the DCI room, there shall be an area that includes, but is not limited to, a monitor and a recorder with the capability of producing first-generation copies.

141.10(10) *Additional requirements.*

a. Audio and video or digital monitoring and recording shall be continuous in the detention areas when someone is being detained. These recordings must be retained for 30 days after the recorded event, unless directed otherwise by the administrator, DCI or court order.

b. The commission, its employees, and DCI agents shall, at all times, be provided immediate access to the surveillance room and all areas of the casino.

141.10(11) *Written plans and alterations.*

a. Every operator or applicant for licensing shall submit to the commission for approval by the administrator and to the DCI for approval a written casino surveillance system plan no later than 60 days prior to the start of gaming operations.

b. A written casino surveillance system plan must include a casino floor plan that shows the placement of the surveillance room and all casino surveillance equipment in relation to the locations required to be covered and a detailed description of the casino surveillance system and its equipment. In addition, the plan may include other information that evidences compliance with these rules by the licensee, operator or applicant.

c. The operator may change the location of the surveillance room, table games, slot machines, and other gaming devices. The surveillance system must also be adjusted, if necessary, to provide the coverage required by these rules. A DCI agent must approve the change in the surveillance system before the relocated surveillance room, table games, slot machines, or other gaming devices may be placed into operation.

EXCEPTION: A commission representative may allow a gambling game to be placed in operation pending approval by a DCI agent.

[1] April 1, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held March 7, 2008. At its meeting held June 9, 2008, the Committee delayed the effective date until the adjournment of the 2009 Session of the General Assembly.

661—141.11(99F) Nongambling hours. Security surveillance will be required during nongambling hours as follows:

141.11(1) *Cleanup and removal time.* At any time that cleanup operations or money removal is being conducted in the casino area, the security surveillance room must be staffed with a minimum of one trained surveillance person.

141.11(2) *Locked-down mode.* Anytime the casino is closed and in a locked-down mode, sufficient surveillance coverage must be conducted to monitor and record the casino in general so that security integrity is maintained. During this period, the presence of a trained security surveillance person shall not be required.

661—141.12(99F) Waivers from requirements. Upon written request of an applicant, licensee, or operator, the director of the DCI may, for just cause, waive any requirement of this chapter, provided that the director finds that all of the following conditions exist:

1. The requirement requested to be waived is not imposed by statute or another provision of law, and the establishment of the requirement is entirely within the authority of the department of public safety.
2. Enforcing the requirement would impose an undue hardship on the applicant, licensee, or operator requesting the waiver.
3. Granting the waiver would not prejudice the substantial legal rights of any person.

4. Substantially equal protection of public health, safety, and welfare to that which would result from the enforcement of the requirement will be afforded through another means.

Each request for a waiver shall be reported to the agency rules administrator of the department of public safety, with an indication of the disposition of the request and a brief explanation of the reasons for granting or denying the waiver.

These rules are intended to implement Iowa Code section 99F.4.

[Filed 11/26/90, Notice 9/19/90—published 12/12/90, effective 1/16/91]
[Filed 10/30/97, Notice 7/16/97—published 11/19/97, effective 1/1/98]
[Filed emergency 6/30/04—published 7/21/04, effective 7/1/04]
[Filed 5/18/05, Notice 3/16/05—published 6/8/05, effective 8/1/05]
[Filed 1/22/08, Notice 10/10/07—published 2/13/08, effective 4/1/08][1]
[Editorial change: IAC Supplement 7/2/08]

[1] April 1, 2008, effective date of ARC 6591B delayed 70 days by the Administrative Rules Review Committee at its meeting held March 7, 2008. At its meeting held June 9, 2008, the Committee delayed the effective date until the adjournment of the 2009 Session of the General Assembly.

CHAPTERS 142 to 149
Reserved

CHAPTER 300
STATE BUILDING CODE—ADMINISTRATION

[Prior to 12/21/05, see rules 661—16.1(103A) to 661—16.500(103A)]

661—300.1(103A) State building code promulgated. Iowa Code section 103A.7 assigns to the building code commissioner authority to promulgate the state building code, with the approval of the building code advisory council, except that adoption of the state historic building code requires the approval of the state historical society board of trustees, rather than the building code advisory council.

The state building code, as authorized by Iowa Code section 103A.7, includes 661—Chapters 16, 300, 301, 302, and 303. The state historic building code is set forth in 661—Chapter 350.

661—300.2(103A) Building code commissioner. The building code commissioner appointed by the commissioner of public safety pursuant to Iowa Code section 103A.4 shall serve as the chief of the building code bureau. The building code commissioner shall adopt, and amend as needed, the state building code, with the approval of the building code advisory council, and the state historic building code, with the approval of the state historical society board. The building code commissioner also shall appoint the board of review from among the council membership. The building code commissioner shall consider any request for the use of alternate materials or methods of construction submitted to the building code bureau pursuant to Iowa Code section 103A.13, and shall either disapprove each such request or shall recommend approval of the request to the building code advisory council.

661—300.3(103A) Building code advisory council. The building code advisory council appointed by the governor pursuant to Iowa Code section 103A.14 shall consider amendments to the state building code proposed by the building code commissioner, other than amendments to the state historic building code. The council shall approve or disapprove any changes to the state building code proposed by the building code commissioner. The council shall also consider and approve or disapprove any requests for use of alternate materials or methods of construction, the approval of which has been recommended to the council by the building code commissioner.

661—300.4(103A) Plan reviews.

300.4(1) *Plans and specifications review—approvals.*

a. Submissions to the building code commissioner of architectural technical documents, engineering documents, and plans and specifications are the responsibility of the owner of the building or facility, although the actual submission may be completed by an authorized agent of the owner or the responsible design professional.

b. "Responsible design professional" means a registered architect or licensed professional engineer who signs the documents submitted.

c. Plans, specifications and other supporting information shall be sufficiently clear and complete to show in detail that the proposed work will comply with the requirements of the applicable provisions of the state building code and with sections 106.1 and 106.1.1 of the International Building Code, 2006 edition.

d. In sections 106.1 and 106.1.1 of the International Building Code, 2006 edition, the word "permit" shall be replaced by the words "plan review."

e. Submittals to the commissioner shall be certified or stamped and signed as required by Iowa Code chapters 542B and 544A unless the applicant has certified on the submittal to the applicability of a specific exception under Iowa Code section 544A.18 and the submittal does not constitute the practice of professional engineering as defined by Iowa Code section 542B.2.

f. Plans and specifications for projects with a construction cost of $1 million or more or projects subject to inspection by the commissioner shall be submitted in an electronic format.

EXCEPTION: For projects with a construction cost of less than $1 million that are subject to inspection by the commissioner, two identical sets of plans and specifications may be submitted in lieu of electronic submittal.

NOTE: The electronic submission of plans and specifications for projects that are not subject to inspection by the commissioner and with a construction cost of less than $1 million is strongly encouraged but not required.

g. Any person planning to submit documents electronically shall contact the bureau for written instructions.

h. Architectural technical submissions, engineering documents, and plans and specifications for construction, renovation, or remodeling of all state-owned buildings or facilities, including additions to existing buildings, shall be submitted to the commissioner for review and comment. Subsequently, a written response by the design professional indicating corrective measures taken to address the commissioner's plan review comments

shall be submitted to and approved by the commissioner prior to the issuance of construction documents for bidding. Bidding may commence on a project after the preliminary meeting provided for in subrule 300.4(3) if all items on the preliminary meeting checklist have been resolved to the satisfaction of the commissioner.

i. Architectural technical submissions, engineering documents, and plans and specifications for the initial construction of any building or facility that will not, when completed, be wholly owned by the state or an agency of the state shall be submitted to the commissioner for review and comment, if the construction is financed in whole or in part with funds appropriated by the state and there is no local building code in effect in the local jurisdiction in which the construction is planned or, if there is such a local building code in effect, it is not enforced through a system which includes both plan reviews and inspections. Subsequently, a written response by the design professional indicating corrective measures taken to address the commissioner's plan review comments shall be submitted to and approved by the commissioner prior to the issuance of construction documents for bidding. Bidding may commence on a project after the preliminary meeting provided for in subrule 300.4(3) if all items on the preliminary meeting checklist have been resolved to the satisfaction of the commissioner.

j. Architectural technical submissions, engineering documents, and plans and specifications for construction, renovation, or remodeling of all buildings or facilities, including additions to existing buildings, to which the state building code applies, other than those subject to paragraph *"h"* or *"i,"* shall be submitted to the commissioner for review and comment, unless applicability of the state building code is based upon a local ordinance enacted pursuant to Iowa Code section 103A.12. Subsequently, a written response by the design professional indicating corrective measures taken to address the commissioner's plan review comments shall be submitted to and approved by the commissioner prior to the issuance of construction documents for bidding. Bidding may commence on a project after the preliminary meeting provided for in subrule 300.4(3) if all items on the preliminary meeting checklist have been resolved to the satisfaction of the commissioner.

k. If the state building code applies to a construction project based upon a local ordinance adopting the state building code, the submission shall be made to the local jurisdiction, provided that the local jurisdiction has established a building department, unless the local jurisdiction requires submission to the commissioner. Review and approval of such documents by the commissioner shall be at the discretion of the commissioner based upon available resources.

l. No project for which a life cycle cost analysis is required to be completed pursuant to Iowa Code section 470.2 shall be approved for construction prior to receipt by the commissioner of the life cycle cost analysis, final approval of the life cycle cost analysis by the commissioner and the department of natural resources pursuant to Iowa Code section 470.7, and the completion of all applicable requirements established in Iowa Code section 470.7.

m. No project for which an energy review is required pursuant to subrule 303.1(3) shall be approved for construction prior to the receipt by the commissioner of the energy review.

NOTE: Compliance with the requirements of paragraphs *"l"* and *"m"* at the earliest practical time is strongly recommended. In no case shall the submission occur later than specified in the applicable statutory provisions and provisions of the state building code.

n. Any submission to the commissioner of architectural technical submissions, engineering documents, or plans and specifications for construction, except for plans to renovate or remodel residential buildings of one or two units, shall include a statement that the construction will comply with all applicable energy conservation requirements.

300.4(2) *Copies and fees.* See 661—Chapters 16, 302, and 303 for fees pertaining to factory-built structures.

a. Copies of the state building code or any portion thereof are available through the Web site of the department of public safety.

NOTE: Codes and standards adopted by reference in the state building code which are published by other organizations, including, but not limited to, the American National Standards Institute, the International Code Council, the International Association of Plumbing and Mechanical Officials, and the National Fire Protection Association, may be purchased from the publishing organization. A copy of each code or standard adopted by reference in the state building code has been deposited in the Iowa state law library.

b. The fees for plan reviews completed by the building code bureau shall be calculated as follows:

Estimated Construction Costs	**Calculation of Plan Review Fee**
Up to and including $1 million	$.58 per thousand dollars or fraction thereof (minimum fee $200)
More than $1 million	$580 for the first $1 million plus $.32 for each additional thousand dollars or fraction thereof
The plan review fees for fire suppression systems and fire alarm systems are separate fees and shall be calculated as follows:	
Fire Protection System Costs	**Plan Review Fee**
Fire suppression systems whose construction cost for materials and installation is calculated to be up to and including $5,000	$100
Fire suppression systems whose construction cost for materials and installation is calculated to be more than $5,000 and up to and including $20,000	$200
Fire suppression systems whose construction cost for materials and installation is estimated to be more than $20,000	$400
Fire alarm systems whose construction cost for materials and installation is calculated to be up to and including $5,000	$100
Fire alarm systems whose construction cost for materials and installation is calculated to be more than $5,000 and up to and including $20,000	$200
Fire alarm systems whose construction cost for materials and installation is estimated to be more than $20,000	$400

Payment of the assigned fee shall accompany each plan when submitted for review. Payment shall be made by money order, check or draft made payable to the Treasurer, State of Iowa.

c. A person who has submitted a plan for review for which a fee has been assessed pursuant to paragraph *"b"* is eligible to receive a refund of the fee if the plan has not been approved or rejected within 60 calendar days of its receipt by the building code bureau. A person who believes that a refund is due shall notify the building code commissioner who shall provide a form to the person who submitted the plan for review to request a refund. If the request for refund is approved, the building code commissioner shall cause a check for the amount of the refund to be issued to the individual or organization that originally paid the fee. If the original submission of the plan is incomplete, the fee shall be refunded only if the plan has not been approved or rejected within 60 days of a full and complete submission of the plan. "Approved or rejected within 60 days" means that a letter approving or rejecting the plan has been presented or mailed to the submitter within 60 days of the date of receipt by the building code bureau, within the meaning of "time" as defined in Iowa Code section 4.1.

300.4(3) *Preliminary meeting.* The responsible design professional for a project shall schedule a preliminary meeting with the building code bureau to discuss code compliance issues early in the design development phase. The responsible design professional shall contact the bureau to schedule the preliminary meeting. There is no separate fee for a preliminary meeting. If the responsible design professional plans to request approval to bid the project as part of the preliminary meeting, the responsible design professional shall request a copy of the document "Preliminary Meeting Checklist" at the time the meeting is scheduled and shall be prepared to address all applicable issues identified on the checklist at the preliminary meeting. Approval to bid the project shall not be given unless all applicable issues identified on the checklist have been addressed to the satisfaction of the commissioner.

300.4(4) *Requests for staged approvals.*

a. Requests for approval to begin foundation work shall be submitted to the building code bureau in writing and may be transmitted by mail, E-mail or fax or in person. Foundation approval may be granted by the bureau in writing, following a preliminary meeting, if the construction plans and specifications are found to be in compliance with the requisite code provisions.

b. Requests for approval to continue construction beyond the foundation, up to and including the shell of the building, shall be submitted to the bureau in writing and may be transmitted by mail, E-mail or fax or in person.

These requests will be evaluated on a case-by-case basis, and approval or denial of the requests will be transmitted to the submitter in a written form.

300.4(5) *Fast-track projects.* While fast-track projects are not encouraged, fast-track projects may be considered by the commissioner on a case-by-case basis. If a fast-track project is initially approved, a written plan of submittal, review and approval will be developed for each project. All projects approved for fast-track review must be submitted in an electronic format that is acceptable to the commissioner.

NOTE: Fast-track projects are not encouraged and will be approved only on the basis of good cause shown.

661—300.5(103A) Inspections.

300.5(1) Any building or facility for which construction is subject to a plan review by the commissioner, except construction involving any building or facility owned by the board of regents or by any institution subject to the authority of the board of regents, shall be subject to inspection by the commissioner or staff of the bureau or division at the direction of the commissioner or by a third party with whom the commissioner contracts to conduct inspections of buildings and facilities subject to the state building code.

300.5(2) Any construction involving any building or facility owned by the board of regents or by an institution subject to the authority of the board of regents shall be subject to inspection by the commissioner or staff of the bureau or division at the direction of the commissioner.

EXCEPTION: Construction which is limited to building additions, renovations or repairs shall not be subject to inspection by the commissioner.

300.5(3) Buildings subject to inspection by the state building code commissioner, except construction involving any building or facility owned by the board of regents or by any institution subject to the authority of the board of regents, shall pay an inspection fee based upon the construction cost of the project. The inspection fee shall be calculated as follows:

Construction Cost	Base Inspection Fee
Up to $100,000	$598
$100,001 to $1,000,000	$645
$1,000,001 to $10,000,000	$722
$10,000,001 and above	$783
Follow-up inspection	$214

The base inspection fee shall cover three inspections—a foundation, rough-in and final. The base inspection fee shall be due and payable at the time completed construction documents are submitted for review. The plan review will not be conducted until the proper base inspection fee is paid. Checks should be made payable to the Treasurer, State of Iowa, and delivered to the bureau office. This fee is separate and distinct from the plan review fee established in subrule 300.4(2).

Additional inspections may occur for any of the following reasons:

a. During one of the three base inspections, code violations are identified that require that a follow-up inspection be conducted to verify that the violations have been corrected.

b. Upon arrival, the inspector finds that the project is not ready for the type of inspection requested.

c. By special request of the project designer, contractor or owner.

d. Upon order of the building code commissioner (no additional charge).

The fee for each additional inspection shall be calculated individually as follows:

One hour on site = $206

One to two hours on site = $240

Two to three hours on site = $273

Three to four hours on site = $307

Four to five hours on site = $341

Five to six hours on site = $374

Additional inspection fees will be billed to the responsible architect or building contractor on a monthly basis. The building may receive only temporary approval for occupancy if unpaid inspection fees remain at the time of final inspection.

Inspection fees and standard operating procedures for construction involving any building or facility owned by the board of regents or by any institution subject to the authority of the board of regents shall be established through a written agreement between the commissioner and the board of regents.

300.5(4) Any person who performs a building code inspection on behalf of the building code commissioner shall have and maintain one of the following: (1) current certification as a commercial building inspector by the International Code Council, or (2) other equivalent certification approved by the building code commissioner. An employee of the department who performs an inspection on behalf of the building code commissioner shall, in addition, meet any requirements for the job class in which the employee is classified as established by the department of administrative services, pursuant to Iowa Code chapter 8A, subchapter IV, part 2.

EXCEPTION: An employee of the department who performs inspections on behalf of the building code commissioner may perform such inspections for no more than six months prior to obtaining the required certification.

661—300.6(103A) Local code enforcement. Provisions of the state building code applicable statewide or applicable in a local jurisdiction which has adopted the state building code by local ordinance may be enforced by the local jurisdiction.

Any local jurisdiction which adopts the state building code by local ordinance may further adopt provisions for the administration and enforcement of the building code by the local jurisdiction. These provisions may include administrative provisions contained in the codes adopted by reference as part of the state building code and may include other provisions at the discretion of the local jurisdiction.

300.6(1) *Creation of department.* There may be established within the governmental subdivision a "building department" which shall be under the jurisdiction of the building official designated by the appointing authority. Within the state building code, including publications adopted by reference within the state building code, the terms "administrative authority," "authority having jurisdiction," and "authorized representative" shall mean the building official.

300.6(2) *Powers and duties of building official.* The building official in those governmental subdivisions establishing a building department shall enforce all the provisions of any applicable building code as prescribed by local law or ordinance and as outlined by Iowa Code section 103A.19.

300.6(3) *Permits only.* Any governmental subdivision that has not established a building department but requires a permit to construct or an occupancy permit or both shall be known as the "issuing authority."

300.6(4) *Statement of compliance with energy conservation requirements.* Any application for a building permit, except for applications to renovate or remodel residential buildings of one or two units, shall include a statement that the construction will comply with all applicable energy conservation requirements.

These rules are intended to implement Iowa Code chapter 103A.

[Filed 12/2/05, Notice 9/14/05—published 12/21/05, effective 4/1/06]
[Filed 11/2/06, Notice 9/27/06—published 11/22/06, effective 1/1/07]
[Filed without Notice 11/2/06—published 11/22/06, effective 1/1/07]
[Filed 10/31/07, Notice 9/12/07—published 11/21/07, effective 1/1/08]
[Filed emergency 6/11/08—published 7/2/08, effective 6/15/08]

CHAPTER 303
STATE BUILDING CODE—REQUIREMENTS FOR ENERGY CONSERVATION IN CONSTRUCTION

[Prior to 12/21/05, see rules 661—16.800(103A) to 661—16.802(103A)]

661—303.1(103A) Scope and applicability of energy conservation requirements.

303.1(1) *Scope.* Rules 661—303.1(103A) through 303.3(103A) establish thermal energy efficiency standards for the design of new buildings and structures or portions thereof, additions to existing buildings, and renovation and remodeling of existing buildings, except for residential buildings of one or two dwelling units, which are intended for human occupancy and which are heated or cooled by regulating their exterior envelopes and selection of their heating, ventilation, and air-conditioning systems, service water heating systems and equipment for the efficient use of energy, and lighting efficiency standards for buildings intended for human occupancy which are lighted.

303.1(2) *Applicability.* Rules 661—303.1(103A) through 661—303.3(103A) apply to design and construction of buildings which are intended for human occupancy throughout the state of Iowa. Any construction of buildings or facilities which are intended for human occupancy and which are heated or cooled is covered, with the exception of renovation and remodeling of residential buildings of one or two dwelling units, which are not covered. Rule 661—303.2(103A) establishes standards for design and construction of residential buildings of three or fewer stories. Rule 661—303.3(103A) establishes standards for design and construction of commercial buildings and residential buildings of four or more stories. The occupancy of any building covered by this chapter shall be determined based upon the occupancy definitions in chapter 3 of the International Building Code, 2006 edition.

303.1(3) *Review by architect or engineer.*

a. Review required. The plans and specifications for all buildings to be constructed which exceed a total volume of 100,000 cubic feet of enclosed space that is heated or cooled shall be reviewed by a registered architect or licensed professional engineer for compliance with applicable energy efficiency standards.

b. Statement of review. A statement that a review has been accomplished and that the design is in compliance with the energy efficiency standards shall be signed and sealed by the responsible registered architect or licensed professional engineer. This statement shall be filed with the commissioner or a local building official on a form approved by the commissioner prior to construction or before obtaining any local permits. The statement shall be filed with the commissioner for any project which is subject to plan review by the building code bureau.

c. Additional buildings. If the plans and specifications relating to energy efficiency for a specific structure have been approved, additional buildings may be constructed from those same plans and specifications without need of further approval if construction begins within five years of the date of approval. Alterations of a structure which has been previously approved shall not require a review because of these changes, provided the basic structure remains unchanged and no additional energy is required for heating, cooling or lighting.

d. Changes to approved plans. Prior to the completion of construction, no changes shall be made to any approved plan or specifications which increase the amount of energy used for heating, cooling, or lighting, unless the changes are approved by the responsible registered architect or licensed professional engineer in writing and notice has been filed with the commissioner or a local building official. The commissioner or a local building official shall be notified of any change which is anticipated to decrease the amount of energy used. Notification pursuant to this paragraph shall be to the commissioner for any project which is subject to plan review by the building code bureau.

661—303.2(103A) Residential energy code. The International Energy Conservation Code, 2006 edition, is adopted by reference as the residential energy code of the state of Iowa building code, applicable to residential construction limited to three or fewer stories throughout the state of Iowa, with the following amendments:

1. Delete sections 101, 103, 104, 105, and 106, and all sections contained within each of these.
2. Strike section 403.2.2 and adopt the following new section 403.2.2 in lieu thereof:

403.2.2 Sealing. All ducts, air handlers, filter boxes, and building cavities used as ducts shall be sealed. Joints and seams shall comply with Section M1601.3.1 of the International Residential Code. Air handlers with a manufacturer's designation for an air leakage of no more than 2 percent of the design air flow rate when tested at an air pressure of 1–inch water gauge when all air inlets, air outlets, and condensate drain port(s) are sealed shall be deemed sealed. Air handlers with filter boxes shall be tested with the filter box in place.

3. Delete chapter 5.

661—303.3(103A) Adoption of nonresidential energy code. The International Energy Conservation Code, 2006 edition, published by the International Code Council, 5203 Leesburg Pike, Suite 600, Falls Church, VA 22041, is hereby adopted by reference as the nonresidential energy code of the state building code, applicable to commercial construction or residential construction of four or more stories within the state of Iowa, with the following amendments:

1. Delete sections 101, 103, 104, 105, and 106, and all sections contained within each of these.
2. Delete chapter 4.

661—303.4(470) Life cycle cost analysis.

303.4(1) *Submission required.* Any public agency as defined by Iowa Code section 470.1 shall prepare a life cycle cost analysis for any new construction having 20,000 square feet of usable floor space which is heated or cooled by a mechanical or electrical system or for any renovation where additions or alterations exceed 50 percent of the value of the facility and affect an energy system. The life cycle cost analysis shall be prepared in compliance with Iowa Code chapter 470 and shall be submitted to the state building code commissioner before construction commences.

303.4(2) *Notification by state agency.* Any public agency which is a state agency as defined in Iowa Code section 7D.34 shall, within 60 days of final selection of a design architect or engineer, notify the commissioner and the department of natural resources of the methodology to be used to perform the life cycle cost analysis. Notice shall be given on the forms provided by the department of natural resources for this purpose. A life cycle cost analysis prepared by a state agency shall be submitted in sufficient time ahead of the release of plans for bids to allow for revisions or additions which may be made to the plans. Public funds shall not be used for the construction or renovation of a facility unless the design for the work is prepared in accordance with Iowa Code chapter 470 and the actual construction or renovation is consistent with the design.

303.4(3) *Exemptions from implementation.* Any public agency responsible for construction or renovation of a public facility shall implement the recommendation of the life cycle cost analysis except as provided in this subrule.

a. A public agency responsible for construction or renovation of a public facility may apply to the commissioner for exemption from any recommendation of the life cycle cost analysis.

b. The public agency shall implement all recommendations of the life cycle cost analysis except those which have been approved for exemption by the commissioner and the director of natural resources.

EXCEPTION: The public agency is not required to implement any recommendation which would result in a violation of any other provision of law. If the public agency determines that compliance with any recommendation of the life cycle cost analysis would result in a violation of law, the public agency shall so notify the commissioner.

c. The commissioner and the director of natural resources shall evaluate each request for an exemption on a case-by-case basis.

d. The commissioner and the director of natural resources shall consider the following factors in determining whether or not to grant an exemption:

(1) The purpose of the facility or renovation;
(2) Preservation of historic architectural features;
(3) Site considerations;
(4) Health and safety concerns;
(5) Compliance with any other provisions of law; and
(6) The technical feasibility of implementing the recommendation. "Technically feasible" means that a recommendation may be implemented without altering major structural features of an existing facility.

661—303.5(103A) Energy review fee. The fee for filing an energy review shall be $25. Payment of the fee, by money order, check, or warrant made payable to Treasurer, State of Iowa, shall be included with the submission of documents for an energy review.

These rules are intended to implement Iowa Code chapter 103A.

[Filed 12/2/05, Notice 9/14/05—published 12/21/05, effective 4/1/06]
[Filed emergency 6/9/06—published 7/5/06, effective 7/1/06]
[Filed 10/5/06, Notice 7/5/06—published 10/25/06, effective 1/1/07]
[Filed 10/31/07, Notice 9/12/07—published 11/21/07, effective 1/1/08]
[Filed emergency 6/11/08—published 7/2/08, effective 6/15/08]

CHAPTERS 304 to 321
Reserved

CHAPTER 322
STATE BUILDING CODE —
MANUFACTURED HOUSING SUPPORT AND ANCHORAGE SYSTEMS

661—322.1 Reserved.

661—322.2(103A) Definitions. The definitions in 661—subrule 16.620(4) apply to the rules in this chapter.

661—322.3 to **322.10** Reserved.

661—322.11(103A) Support and anchorage of manufactured homes.

322.11(1) Manufactured homes shall be installed in accordance with one of the following paragraphs, as applicable:

a. Homes manufactured prior to October 20, 2008, shall be installed with support and anchorage as recommended by the manufacturer and as required by 24 CFR Part 3280, Manufactured Home Construction and Safety Standards, as published April 1, 2004; or

b. Homes manufactured on or after October 20, 2008, shall be installed in accordance with 24 CFR Part 3285, Model Manufactured Home Installation Standards, as published October 19, 2007; or

c. With a support and anchorage system designed by a licensed professional engineer; or

d. With a support and anchorage system that complies with subrules 322.11(2) and 322.11(3). This option shall apply only if the manufacturer's instructions are not available or the unit was manufactured before June 15, 1976. "The manufacturer's instructions are not available" means that the installer has requested and been unable to obtain the instructions from the manufacturer or its successor company and has requested and been unable to obtain the instructions from the building code bureau.

EXCEPTION: Minor adjustments in pier locations may be necessary to avoid utility and service lines. Additional supports may be needed to ensure that the maximum allowed distance between supports and anchors is not exceeded.

322.11(2) Requirements for support system installations.

a. Piers placed on foundations shall be installed and centered directly under the main frame longitudinal beams. The piers should not be farther apart than 10 feet on centers for manufactured homes 12 feet wide or less and not more than 8 feet on centers for manufactured homes over 12 feet wide to less than 16 feet wide and no more than 6 feet on centers for manufactured homes 16 feet wide or more. The main frame, front or back, should not extend farther than 2 feet beyond the centerline of the end piers.

NOTE: When making excavations for footings and piers on private property, installers shall take precautions to ensure that no telephone, electrical, plumbing or water lines are contacted. Utility line locations shall be verified with the property owner or property owner's representative.

b. Pier foundations shall be placed below the frostline on level, undisturbed soil, or on controlled fill that is free of grass and organic materials. (A small amount of sand may be of use to provide a level surface.) All pier foundations shall be set level, and piers must be installed plumb. The pier foundation shall be at least a 16″ × 16″ × 4″ solid concrete pad, precast or poured in place, or other approved material. Two nominal 4″ × 8″ × 16″ solid concrete blocks may be used provided that the joint between the blocks is parallel to the main frame longitudinal beam. Concrete used in foundations shall have a 28-day compressive strength of not less than 3,000 pounds per square inch (3,000 psi).

c. Unless otherwise directed by the owner of the site, the soil-bearing capacity of the site may be assumed to be 2,000 pounds per square foot. The acceptable construction under this subrule is based upon a soil-bearing capacity of 2,000 pounds per square foot. Sites with less soil-bearing capacity will require increased-size footings.

EXPLANATION: The permissible footing sizes and pier spacing are based upon a combined live and dead load of 65 pounds per square foot of unit. This assumes that the full snow and internal live load will not be present at the same time.

d. Piers may be constructed of concrete or undamaged nominal 8″ × 8″ × 16″ concrete blocks, open-celled or solid, placed on the pier foundation. All open-celled concrete block shall be installed with the cells of the block in a vertical position. Nominal 2″ × 8″ × 16″ or nominal 4″ × 8″ × 16″ solid concrete blocks may be utilized as needed to achieve the necessary heights of the piers for a particular installation. A nominal 2″ × 8″ × 16″ wood plate, or equivalent, shall be placed on top of each pier, unless there is at least 4 inches of solid block, with shims fitted and driven between the wood plate or solid block and the main frame longitudinal beam. The wood blocking

shall not occupy more than a nominal 2 inches of vertical space, and shims shall not occupy more than 1 inch of vertical space. Shims which have a thickness of more than 3/8″ shall be hardwood.

(1) Piers up to 40 inches in height, except corner piers over three blocks high (a nominal 24″), may be of single-block construction and shall be installed transverse (right angle) to the main frame longitudinal beam.

(2) Piers over 40 inches in height but not exceeding 80 inches in height and corner piers over three blocks high shall be of double-block construction with every other course either parallel or transverse (right angle) to the main frame longitudinal beam. These piers shall be capped with a nominal 16″ × 16″ × 4″ solid concrete block or equivalent. Wood blocking and hardwood shims shall be installed accordingly.

(3) Piers over 80 inches in height shall be of reinforced concrete or of double-block construction and installed exactly according to the procedure given in subparagraph (2) above. Only celled concrete blocks shall be used (with open cells vertical) with 3/8″ diameter or larger steel reinforcing rods placed in the pier corners and all cells filled with 3,000 psi concrete. Wood blocking and shims shall be installed accordingly.

322.11(3) Requirements for anchorage systems. When instructions are not provided by the manufacturer, ties shall be attached vertically and diagonally to a system of ground anchors in a manner as illustrated in Figures 4 and 5. The minimum number of ties required are listed in Table 6–A. There shall be a diagonal tie between the ground anchors and the unit at each vertical tie. Additional diagonal ties may be required between vertical ties. The ties shall be as evenly spaced as practicable along the length of the unit with not over 8 feet open on each end.

a. Ties may be either steel cable, steel strapping, or other materials that meet the requirements of 322.11(3)*"f."* Ties are to be fastened to ground anchors and drawn tight with galvanized turnbuckles or yoke-type fasteners and tensioning devices. Turnbuckles shall be ended with jaws of forged or welded eyes (hook ends are not approved).

b. When continuous straps (over-the-top tie-downs) are provided as vertical ties, they should be positioned at rafters and studs to prevent structural damage. Where a vertical tie and diagonal tie are located at the same place, both ties may be connected to a single doublehead ground anchor provided that the anchor used is capable of carrying the combined loads and the anchor is included on a list of approved products maintained by the commissioner.

c. Cable used for ties shall be either galvanized steel or stainless steel and shall have a breaking strength of at least 4,725 pounds. Cable should be either 7/32″ diameter or greater (7 × 7) steel cable or ¼″ diameter or greater (7 × 19) aircraft cable. All cable ends should be secured with at least two I-bolt-type cable clamps or other nationally approved fastening devices.

d. When flat steel straps are used as ties, they shall be type 1, class B, grade 1, 1¼″ wide and 0.035″ thick, conforming with federal standard QQ-S-781-F, with a breaking strength of at least 4,725 pounds. Zinc coating (weather protection) shall be a minimum of 0.30 ounces per square foot of surface. Steel strap ties shall terminate with D-rings, bolts, or other nationally approved fastening devices that will not cause distortion or reduce the breaking strength of the ties.

e. The direction of pull of the diagonal ties should be at a right angle to the main frame longitudinal beam. Connection of the diagonal tie to the main frame longitudinal beam should be in accordance with anchor system instructions for those fastening devices. When steel strap ties are used, care should be exercised that the minimum bending radius is adhered to so the breaking strength is not reduced.

f. The anchorage materials shall be capable of resisting an allowable minimum working load of 3,150 pounds (pullout in a vertical direction) with no more than 2 percent elongation and shall withstand a 50 percent overload. All anchorage materials shall be resistant to weathering deterioration at least equivalent to that provided by a coating of zinc on steel strapping of not less than 0.30 ounces per square foot surface coated. Anchors to reinforced concrete slab or to rock shall be of comparable strength as provided within this paragraph.

Each ground anchor, when installed, shall be capable of resisting an allowable working load at least equal to 3,150 pounds in the direction of the ties plus a 50 percent overload (4,750 pounds total) without failure. Failure shall be considered to have occurred when the point of connection between the tie and anchor moves more than 2 inches at 4,750 pounds in the direction of the vertical tie when anchoring equipment is installed in accordance with the anchorage manufacturer's instructions. Those ground anchors which are designed to be installed so that the loads on the anchor are other than direct withdrawal shall be designed and installed to resist an applied design load of 3,150 pounds at 45° from horizontal without displacing the anchor more than 4 inches horizontally at the point where the tie attaches to the anchor.

Anchors designed for connection of multiple ties shall be capable of resisting the combined working load and overload consistent with the intent expressed in this paragraph.

g. Ground anchors shall be installed so that the load-carrying portion of the anchor in its final working position is below the frost depth (42 inches), and the anchor head shall be at ground level. Total anchor length shall be more than 42 inches as necessary.

NOTE: When installing ground anchors on private property, installers shall take precautions to ensure that no telephone, electrical, plumbing or water lines are contacted. Utility line locations shall be verified with the property owner or property owner's representative.

TABLE 6–A
MINIMUM NUMBER OF TIEDOWNS
REQUIRED FOR SINGLEWIDE MOBILE HOMES

MOBILE HOME BOX LENGTH NOT EXCEEDING	MINIMUM NUMBER OF TIEDOWNS PER SIDE	
	DIAGONAL TIES	VERTICAL TIES*
40′–0″	3	2
54′–0″	3	2
73′–0″	4	2
84′–0″	5	2

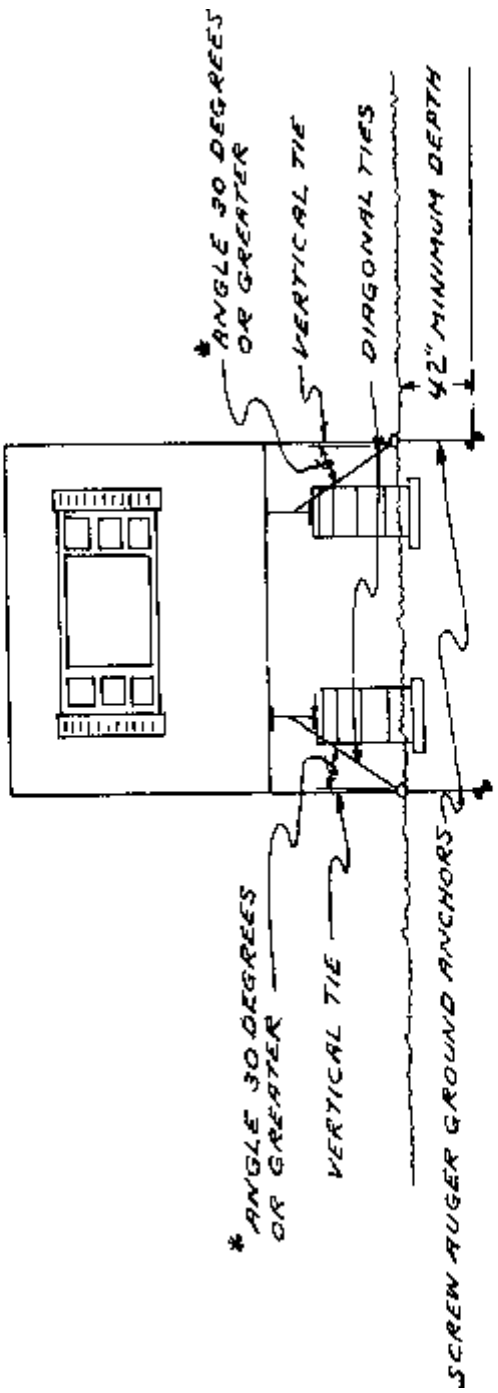
*If more than the minimum number of vertical or diagonal ties have been supplied, they shall all be used.

NOTES:

1. Doublewide mobile homes shall comply with Table 6–A except that no vertical ties are required.
2. Wherever a vertical tie and a diagonal tie lie in a plane that is vertical and transverse to the main longitudinal beam, both ties may be connected to the same ground anchor, providing that particular anchor withstands both loadings.
3. This table shall be used only if there are no manufacturer's approved installation requirements.

FIGURE 4

MOBILE HOME TIEDOWN

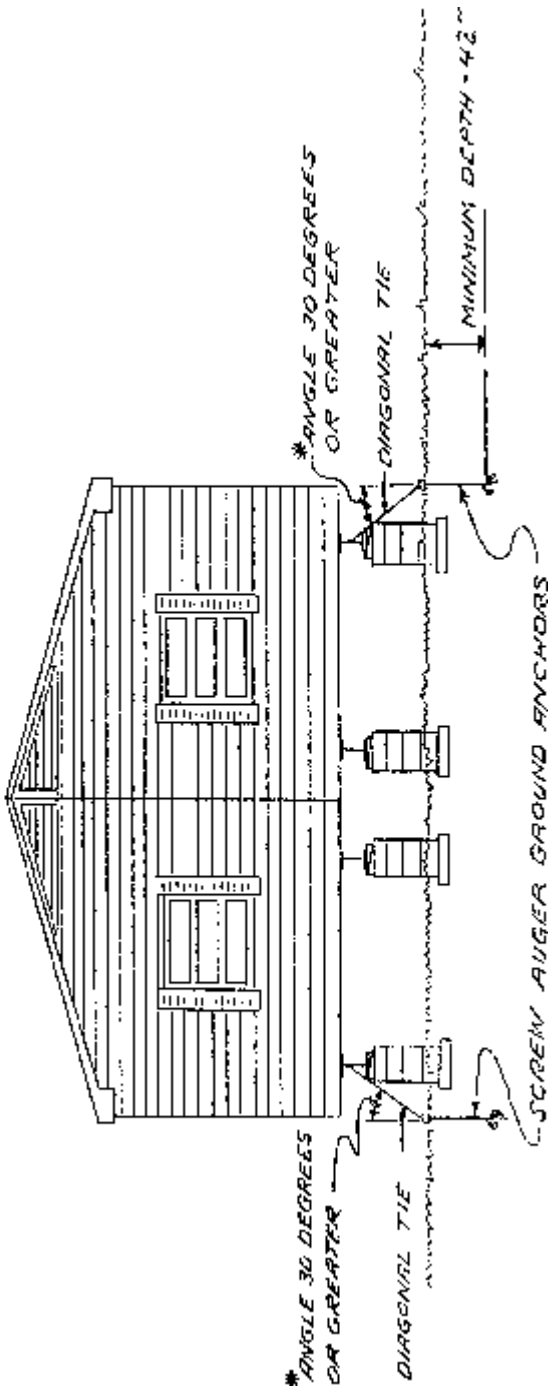


*DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.

FIGURE 5

DOUBLE WIDE MOBILE HOME TIEDOWN

*DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.



661—322.12 to **322.19** Reserved.

661—322.20(103A) Fees.

322.20(1) All remittances of fees shall be made by check or money order payable to Iowa Department of Public Safety — Building Code Bureau. Fees shall be remitted to the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 215 East 7th Street, Des Moines, Iowa 50319.

322.20(2) The following table sets out the fee schedule for the manufactured home program.

Installation Seal	$25
Installation Seal Replacement	$10
Verification Inspections Requested by Installer or Owner	No Charge
Ground Support and Anchoring System Approval	$100

These rules are intended to implement Iowa Code section 103A.9.

[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]

CHAPTERS 323 to 349
Reserved

CHAPTER 372
MANUFACTURED OR MOBILE HOME RETAILERS, MANUFACTURERS, AND DISTRIBUTORS

661—372.1(103A) Definitions. The definitions in 2006 Iowa Acts, Senate File 2394, section 1, are made part of this chapter. In addition, the following words and phrases when used in this chapter shall have these meanings respectively ascribed to them, except when the context otherwise requires.

"Bureau" means the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309.

"Certificate of title" means a document issued by the appropriate official which contains a statement of the owner's title, the name and address of the owner, a description of the vehicle, a statement of all security interests and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms "title certificate," "title only," and "title" are synonymous with the term "certificate of title."

"Commissioner" means the building code commissioner.

"Department" means the Iowa department of public safety.

"Manufacturer's certificate of origin" means a certification signed by the manufacturer or importer that the manufactured or mobile home described has been transferred to the person or retailer named and that the transfer is the first transfer of the manufactured or mobile home in ordinary trade and commerce. The description shall include the make, model year, vehicle identification number, and other information which may be required by statute or rule. The terms "manufacturer's statement," "importer's statement or certificate," "MSO" and "MCO" are synonymous with the term "manufacturer's certificate of origin."

"Model year" means the year of original manufacture or the year certified by the manufacturer.

661—372.2(103A) Criteria for obtaining a manufactured or mobile home retailer's license.

372.2(1) *Licensing information.* Information concerning license requirements may be obtained from the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309.

372.2(2) *Application.* A manufactured or mobile home retailer shall file a completed application form at least 30 days prior to the expiration of a current license or, if the application is for an initial license, 30 days prior to the date on which the retailer anticipates doing business. A retailer may not operate without a current license.

372.2(3) *Expiration.* Each license expires on January 1 of the calendar year following the year in which the license is issued, except that a license issued in December of any year shall cover the following calendar year.

372.2(4) *Fees.* The license fee established by statute is $100 annually or for any portion of a year, except that a license issued in December of any year is valid for the following calendar year and any retailer with a license valid for a particular calendar year may continue to operate under that license until the end of January of the following calendar year.

372.2(5) *Surety bond.* The applicant shall obtain a surety bond in the amount of $50,000. The original bond shall be filed with the department. The bond shall provide for a 30-day notice to the bureau, prior to cancellation. The bureau shall notify the bonding company of any violations of Iowa Code chapter 103A or these rules by the license holder. The bureau shall notify the retailer by mail or personal service that the retailer's license shall be revoked the same date the bond is canceled unless the bond is reinstated or a new bond is filed.

372.2(6) *Place of business.* The applicant shall maintain a place of business at a designated location. A manufactured or mobile home may be used as an office if the home's taxes are current. The place of business shall include telephone service and an office area in which are kept the business records, manufacturer's certificates of origin, certificates of title or other evidence of ownership of each manufactured or mobile home offered for sale.

372.2(7) *Separate place of business.* A separate retailer's license shall be obtained for each county in which the applicant maintains a place of business.

661—372.3(103A) Operation under distinct name. A manufactured or mobile home retailer shall not represent or advertise the business under any name other than the name that appears on the retailer's license.

661—372.4(103A) Supplemental statements. A manufactured or mobile home retailer shall file with the commissioner a written statement upon change of name or change of location of the retailer's place of business.

The written statement shall be filed within ten days of the change with a fee of $100 in payment for a new license reflecting the change.

661—372.5(103A) Denial, suspension, or revocation—civil penalties.

372.5(1) The commissioner may deny the issuance or renewal of a license if the applicant has committed any violation of any provision of law applicable to the operation of a business required to be licensed pursuant to this chapter.

372.5(2) The commissioner may suspend or revoke a license for any violation of this chapter or of any other provision of law applicable to the operation of a business required to be licensed pursuant to this chapter.

372.5(3) The commissioner may impose a civil penalty for any violation of this chapter or of Iowa Code chapter 103A relating to the manufacture of a manufactured or mobile home. A civil penalty may be imposed in addition to a denial of the issuance or renewal of a license, a suspension of a license, or a revocation of a license. A civil penalty shall not be imposed in lieu of a denial of the issuance or renewal of a license or of a revocation of a license. A civil penalty shall not exceed $1,000 for each offense. Each violation involving a separate manufactured or mobile home, or a separate failure or refusal to allow an act to be performed or to perform an act as required by this chapter or Iowa Code chapter 103A, constitutes a separate offense. However, the maximum amount of civil penalties which may be assessed for any series of violations occurring within one year from the date of the first violation shall not exceed $1 million.

372.5(4) Suspension or revocation for nonpayment of child support. The following procedures shall apply to actions taken by the building code commissioner on a certificate of noncompliance received from the Iowa department of human services pursuant to Iowa Code chapter 252J:

a. The notice required by Iowa Code section 252J.8 shall be served upon the licensee by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the licensee may accept service personally or through authorized counsel.

b. The effective date of revocation or suspension of certification of a licensee, as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service upon the licensee.

c. Licensees shall keep the building code commissioner informed of all court actions and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J and shall provide the building code commissioner with copies, within 7 days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

d. All applicable fees for an application or reinstatement must be paid by the licensee before a license will be issued, renewed, or reinstated after the building code commissioner has denied the issuance or renewal of a license or has suspended or revoked a license pursuant to Iowa Code chapter 252J.

e. In the event a licensee files a timely district court action following service of a notice pursuant to Iowa Code sections 252J.8 and 252J.9, the building code commissioner shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed. For the purpose of determining the effective date of revocation or suspension of the certification, the building code commissioner shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

f. Suspensions or revocations imposed pursuant to this subrule may not be appealed administratively within the department of public safety.

NOTE: The procedures established in subrule 372.5(4) implement the requirements of Iowa Code chapter 252J. The provisions of Iowa Code chapter 252J establish mandatory requirements for an agency which administers a licensure program, such as the one established in this chapter, and provide that actions brought under these provisions are not subject to contested case procedures established in Iowa Code chapter 17A, but must be appealed directly to district court.

372.5(5) Appeals. Any denial, suspension, or revocation of a certification, or any civil penalty imposed upon a licensee under this rule, other than one imposed pursuant to subrule 372.5(4), may be appealed by the licensee within 14 days of receipt of the notice. Appeals of actions taken by the building code commissioner under this rule shall be to the commissioner of public safety and shall be treated as contested cases, following the procedures established in rules 661—10.301(17A) through 661—10.332(17A).

661—372.6(103A,321) Sale or transfer of manufactured or mobile homes. The following criteria apply to the sale or transfer of manufactured or mobile homes.

372.6(1) *Retailer sales.*

a. A manufactured home, which was manufactured on or after June 15, 1976, and which is owned by a retailer, shall not be offered for sale unless the retailer has a properly assigned manufacturer's certificate of origin or a certificate of title, a seal from the United States Department of Housing and Urban Development properly attached, a data plate attached by the manufacturer, and a manufacturer's installation manual for the home, if the manual is available to the retailer. A retailer shall not sell a manufactured or mobile home owned by the retailer without delivering to the transferee a manufacturer's certificate of origin or a certificate of title duly assigned to the transferee.

b. A used manufactured or mobile home with an Iowa title assigned to the retailer shall not be reassigned by the retailer. After acquiring the used home, the retailer shall obtain a new certificate of title as required by law.

372.6(2) *Transfers.* A manufactured or mobile home not owned by a retailer may be offered for sale and sold by a retailer under the following conditions:

a. The manufactured or mobile home owner and retailer shall enter into a written listing agreement, signed by the owner or by one owner of a manufactured or mobile home owned jointly by more than one person, and signed by the retailer, which shall be dated and include the following provisions:

(1) The make, model year, and vehicle identification number.

(2) The period of time that the agreement shall remain in force.

(3) The commission or other remuneration that the retailer is entitled to receive.

(4) The price for which the manufactured or mobile home shall be sold.

(5) The name and address of the secured party, if the manufactured or mobile home is subject to a security interest.

(6) Any additional terms to which the owner(s) and retailer agree.

b. If current taxes have not been paid, the taxes and penalties shall be paid from the proceeds of the sale.

c. The retailer shall inform a prospective purchaser of a manufactured or mobile home that the home is not owned by the retailer and, if requested by a prospective purchaser, provide the name and address of the owner(s).

d. An offer to purchase a manufactured or mobile home shall be in writing.

e. The retailer shall make a written disclosure to the purchaser of the description of the manufactured or mobile home; the name and address of the owner; if the home is subject to a security interest, the name and address of the secured party; and, if the current taxes have not been paid, the amount of taxes and penalties due. The disclosure statement shall be signed and dated by the transferee. The disclosure statement shall be in duplicate. The original shall be given to the transferee and the duplicate retained by the retailer, at the retailer's principal place of business, for a period of three years.

f. The documents required pursuant to this subrule shall be made available to the commissioner or any designee of the commissioner for inspection upon request.

661—372.7(103A) Right of inspection. The commissioner or any designee of the commissioner shall have the authority to inspect manufactured or mobile homes, business records, manufacturer's certificates of origin, certificates of title or other evidence of ownership of each manufactured or mobile home offered for sale.

661—372.8(103A) Criteria for obtaining a manufactured or mobile home manufacturer's or distributor's license. Information concerning license requirements may be obtained from the Building Code Bureau, Fire Marshal Division, Iowa Department of Public Safety, 401 S.W. 7th Street, Suite N, Des Moines, Iowa 50309.

372.8(1) *Application.* A manufactured or mobile home manufacturer or distributor shall file a completed application form at least 30 days prior to the expiration of a current license, or if the application is for an initial license, 30 days prior to the date on which the manufacturer or distributor anticipates doing business. A manufacturer or distributor may not operate without a current license.

372.8(2) *Expiration.* Each license expires on January 1 of the calendar year following the year in which it is issued, except that a license issued in December of any year shall cover the following calendar year.

372.8(3) *Fees.* The license fee established by statute is $100 annually or for any portion of a year, except that a license issued in December of any year is valid for the following calendar year and any manufacturer or distributor with a license valid for a particular calendar year may continue to operate under that license until the end of January of the following calendar year.

372.8(4) *Notification.* Manufactured or mobile home manufacturers and distributors shall, within ten days of the fact, notify the bureau in writing of:

a. Any change in the name, method of doing business or location of the place of business as shown on the license and shall include a fee of $100 in payment of a new license reflecting the change.

b. Issuance of a contract with a person in this state to sell new manufactured or mobile homes at retail.

c. Any change in the trade names of manufactured or mobile homes being manufactured for delivery in this state.

372.8(5) *Required acts.* Manufactured or mobile home manufacturers and distributors shall furnish sample manufacturer's certificates of origin to the commissioner for each make of manufactured or mobile home assembled by the manufacturer for delivery in this state.

661—372.9(17A,103A) Waivers. Applications for waivers of the provisions of the rules in this chapter may be submitted and shall be considered under the procedures and criteria established in rule 661—10.222(17A), except for the following:

1. Petitions for waivers shall be addressed to:

Building Code Commissioner
Fire Marshal Division
Iowa Department of Public Safety
401 S.W. 7th Street, Suite N
Des Moines, Iowa 50309

2. Consideration of and determinations regarding requests for waivers of any provision of this chapter shall be the responsibility of the building code commissioner. Any reference to "department" in rule 661—10.222(17A) shall be replaced, for purposes of this rule, with "building code commissioner."

These rules are intended to implement Iowa Code chapter 103A as amended by 2006 Iowa Acts, Senate File 2394.

[Filed 11/2/06, Notice 9/27/06—published 11/22/06, effective 1/1/07]
[Filed emergency 11/29/06—published 12/20/06, effective 1/1/07]

CHAPTER 373
Reserved

CHAPTER 374
MANUFACTURED HOUSING INSTALLER CERTIFICATION

661—374.1(103A) Certification program. There is established in the building code bureau of the fire marshal division a manufactured housing installer certification program. The program may be contacted by E-mail at mhinfo@dps.state.ia.us, by telephone at (515)725-6145, or by mail at the following address:

Manufactured Housing Installer Certification Program
Building Code Bureau
Fire Marshal Division
Iowa Department of Public Safety
215 East 7th Street
Des Moines, Iowa 50319

661—374.2(103A) Certified installer required. There shall be at least one person certified as a manufactured housing installer present at the installation of any manufactured home in Iowa. The installation of a manufactured home shall be under the direct supervision of a certified manufactured housing installer, who shall be present at all times at the installation site while any installation work is proceeding.

EXCEPTION: Installation of a manufactured home may be completed by the owner of the home, if the home is the primary residence of the person completing the work, whether or not the person is certified as a manufactured housing installer, provided that the work is inspected as required and that a state-certified installer certifies compliance with appropriate provisions of this chapter, 661—Chapter 16, and 661—Chapter 322.

661—374.3(103A) Requirements for installer certification. An applicant for certification must meet all of the following requirements:

374.3(1) The applicant must be at least 18 years old.

374.3(2) The applicant must have a minimum of one year of experience in the installation, construction or inspection of manufactured homes. Proof of experience shall be submitted on a notarized affidavit submitted with the application to the commissioner.

374.3(3) The applicant must successfully complete a minimum of eight hours of training approved by the commissioner. Training shall be based on the manufactured housing installation standards published by the U.S. Department of Housing and Urban Development and material approved by the commissioner.

374.3(4) The applicant must have received a passing grade on an examination approved by the commissioner.

661—374.4(103A) Certification fee. The certification fee shall be $300, payable at the time of application, and shall cover certification for three years. Fees shall be remitted in the form of a check or money order, payable to the Iowa Department of Public Safety – Building Code Bureau. The following should be written in the memo portion of the check: "Manufactured Housing Installer Certification." Applications and fees received after July 1 of any year will cover the remainder of the fiscal year in which they are received and the following two state fiscal years. Applications and fees received prior to July 1 of any year shall cover the period through June 30 of the third year following.

EXCEPTION: If as of June 1, 2009, statutory language regarding fees collected for certification and recertification of manufactured housing installers does not clearly provide that any such fees collected are exempt from reversion to the state treasury pursuant to Iowa Code section 8.33, then all current certificate holders who paid the $300 fee shall have $200 of the fee refunded.

661—374.5(103A) Certification period. Installer certifications and recertifications shall be issued for three years and shall expire on June 30 of the third year of the certification period. Certifications and recertifications issued after July 1 shall cover the remainder of the fiscal year in which they are issued and the following two state fiscal years.

EXCEPTION: If as of June 1, 2009, statutory language regarding fees collected for certification and recertification of manufactured housing installers does not clearly provide that any such fees collected are exempt from reversion to the state treasury pursuant to Iowa Code section 8.33, then all current certificates shall be modified to expire after one year rather than three years from their effective dates.

661—374.6(103A) Review of application for certification. Upon receipt of an application for certification or recertification, staff of the building code bureau shall review the application and recommend approval or denial to the building code commissioner. If an application is approved, the certificate shall be issued to the applicant. If an application is denied, the applicant shall be notified and given an explanation of the reason or reasons for denial. Denials of applications by the building code commissioner may be appealed according to the contested case provisions of 661—Chapter 10. An appeal may be filed as a request for contested case proceeding as provided in rule 661—10.304(17A). An appeal must be filed within 30 days of the date of the denial.

661—374.7(103A) Certification renewal and continuing education.

374.7(1) A certification may be renewed if the installer applying for recertification has completed 12 hours of continuing education, approved by the commissioner, during the three-year certification period. Such training shall be submitted to the commissioner for review and approval prior to the date the training is received. Requests for approval shall be submitted on a form supplied by the commissioner, with supporting documentation.

374.7(2) Any installer who has not been recertified by the expiration date of the installer's certification shall not be allowed to work as an installer until a valid certification is obtained.

374.7(3) Failure to renew a certification within 60 days of its expiration shall require successful completion of an approved examination.

374.7(4) The recertification fee shall be $300, payable at the time of application. Fees shall be remitted in the form of a check or money order, payable to the Iowa Department of Public Safety – Building Code Bureau. The following shall be written in the memo portion of the check: "Manufactured Housing Installer Certification." Applications and fees received after July 1 shall cover the remainder of the fiscal year in which they are received and the following two years.

661—374.8(103A) Suspension or revocation of certification. An installer certification may be suspended or revoked for cause pursuant to a recommendation by the staff of the building code bureau to the building code commissioner. Suspension or revocation of an installer certification may be appealed subject to the provisions of 661—Chapter 10 for contested case proceedings. An appeal may be filed as a request for contested case proceeding as provided in rule 661—10.304(17A). An appeal must be filed within 30 days of the date of the suspension or revocation.

661—374.9(103A) Civil penalties. In addition to possible suspension or revocation of a certification, a person who violates the rules governing manufactured housing installation may be subject to civil penalties. Civil penalties may be assessed by the building code commissioner based on recommendation from staff of the building code bureau. Assessments of civil penalties may be appealed subject to the provisions of 661—Chapter 10 for contested case proceedings. An appeal may be filed as a request for contested case proceeding as provided in rule 661—10.304(17A). An appeal must be filed within 30 days of the date of the assessment of the civil penalty.

661—374.10(103A) Inspections.

374.10(1) The installation of any manufactured home as defined in Iowa Code section 103A.51 shall be subject to inspection by a representative of the building code bureau.

374.10(2) Any person planning to install a manufactured home shall notify the building code bureau of the person's intent to install a home at least three business days prior to the date of installation.

374.10(3) A manufactured home shall not be occupied until approval has been given by the building code bureau. If the inspection of the home is not completed within the three-business-day notification period, approval may be given by the building code bureau to proceed with the installation.

These rules are intended to implement Iowa Code section 103A.59.

[Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]

CHAPTERS 375 to 399
Reserved

CHAPTER 122
KEEP IOWA BEAUTIFUL PROGRAM

761—122.1(314) Purpose. The purpose of the keep Iowa beautiful program established by Iowa Code section 314.28 is to provide funds for litter prevention, waste management and recycling, and beautification projects. The program is funded from moneys appropriated to the department by the general assembly from the keep Iowa beautiful fund. These rules establish eligibility standards and the application and approval procedures for project funding.

761—122.2(314) Information. Information and application forms regarding the keep Iowa beautiful program may be obtained from the following sources:

1. Office of Systems Planning, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.
2. Keep Iowa Beautiful, 300 E. Locust Street, Suite 100, Des Moines, Iowa 50309; telephone (515)323-6507. Keep Iowa Beautiful is a nonprofit, charitable organization.
3. The following Web sites: www.keepiowabeautiful.com or www.iowadot.gov/forms.

761—122.3(314) Allocation of funds. The director of transportation shall allocate up to 70 percent of the moneys appropriated to the department from the keep Iowa beautiful fund to community projects. Community projects are those that will have a local impact. The director shall allocate the remaining funds to the Keep Iowa Beautiful organization for projects that will have a statewide impact.

761—122.4 Reserved.

761—122.5(314) Community projects.

122.5(1) *Applicant eligibility.* Any public or private, nonprofit organization is eligible to apply for and receive funds for a community project under the keep Iowa beautiful program. Once a project is approved, the applicant is termed the "project sponsor."

122.5(2) *Project eligibility.*

a. A community project must have as its primary purpose litter removal or prevention, improving waste management or recycling efforts, or beautification.

b. The purchase of motorized equipment costing more than $1,000 is not eligible for funding.

c. Administrative and operating costs of the project sponsor are not eligible for funding.

d. A community project must be completed within one year.

122.5(3) *Funding.*

a. Projects are funded on a grant basis.

b. A project need not include matching contributions. However, the higher degree of match, the more likely a project will be approved.

c. Keep Iowa beautiful funds approved for a project are for a maximum dollar amount. Cost overruns are the responsibility of the project sponsor.

122.5(4) *Project application.*

a. A project application shall be submitted to the office of systems planning on the application form prescribed by the department. Funding for projects is approved each year. The application deadline is December 31 of each year or on the first workday following that date if December 31 falls on a weekend. Applications must be received by the department no later than 4:30 p.m. on the due date.

b. A project application shall include:

(1) The name and a description of the applicant organization.

(2) The applicant's mailing address and telephone number, along with the name of the contact person who will serve as project liaison with the department.

(3) A description of the project, including its purpose and the expected results.

(4) A timetable for the project.

(5) The amount of keep Iowa beautiful funds requested.

(6) The value of matching contributions. See paragraph *"c"* of this subrule for a discussion of matching contributions.

(7) An estimate of the hours of volunteer labor anticipated.

(8) On a separate sheet, an itemized budget for the total project. For each funding source (i.e., keep Iowa beautiful funds or matching contributions), the applicant shall list each item to be purchased or the resource to be donated along with its cost or value.

c. Matching contributions include cash donations from sources other than the keep Iowa beautiful fund, in-kind contributions, and volunteer labor.

(1) In-kind contributions include donated materials, supplies and business services.

(2) Business services are those services provided by a business or by a person whose trade, profession or occupation is to provide those services.

(3) The value of an in-kind contribution is its purchase price or market value.

(4) The value of volunteer labor shall be based on the minimum wage rate for the state in effect on the application deadline for each cycle.

122.5(5) *Review committee.* A keep Iowa beautiful review committee shall evaluate all applications and recommend community projects to be funded and the amount to be funded for each project. The committee is composed of individuals appointed by the director of transportation.

122.5(6) *Project selection.* Considering the recommendations of the review committee, the director of transportation shall select community projects to be funded and the amount to be funded for each project.

122.5(7) *Project selection criteria.*

a. The primary criterion for determining funding priorities is the anticipated effectiveness of a project to clean up or prevent litter, improve waste management or recycling efforts, improve the attractiveness of an area, or beautify a site.

b. The selection committee may balance the use of funds between rural and urban communities, various areas of the state, or diverse groups of citizens.

c. Higher priority shall be given to those applications that leverage keep Iowa beautiful funds with matching contributions.

122.5(8) *Project agreement.* Once a project is approved, the approved project application constitutes the agreement between the department and the project sponsor.

122.5(9) *Project administration.*

a. The project sponsor is accountable for the keep Iowa beautiful funds used on the project.

b. The project sponsor shall submit a report to the office of systems planning upon completion of the project. The report shall describe the project, include an accounting of the use of keep Iowa beautiful funds used on the project, and state the results and effectiveness of the project.

c. The department may audit all project costs incurred for compliance with the agreement, including costs that are part of the matching contribution.

122.5(10) *Noncompliance.* The department may seek repayment of keep Iowa beautiful funds for any of the following reasons:

a. The project sponsor fails to fulfill the terms of the agreement.

b. The department finds that the application contains material inaccuracies, omissions, errors or misrepresentations.

c. The time schedule for project completion is misrepresented or has not been maintained.

761—122.6 Reserved.

761—122.7(314) Statewide projects.

122.7(1) *Agreement.* The use of keep Iowa beautiful funds for statewide projects shall be governed by a written agreement between the department and the Keep Iowa Beautiful organization. The agreement shall specify the approved funding level and the conditions for funding.

122.7(2) *Project eligibility.*

a. A statewide project must have as its primary purpose litter removal or prevention, improving waste management or recycling efforts, or beautification.

b. The purchase of motorized equipment costing more than $1,000 is not eligible for funding.

c. Administrative and operating costs of the Keep Iowa Beautiful organization are not eligible for funding.

122.7(3) *Project administration.*

a. The Keep Iowa Beautiful organization is accountable for the keep Iowa beautiful funds allocated to it.

b. The Keep Iowa Beautiful organization shall submit a report to the office of systems planning each year. The report shall describe the projects funded using keep Iowa beautiful funds, include an accounting of the use of keep Iowa beautiful funds used on each project, and state the results and effectiveness of each project.

c. The department may audit all project costs incurred for compliance with the agreement.

122.7(4) *Noncompliance.* The department may seek repayment of keep Iowa beautiful funds if the Keep Iowa Beautiful organization fails to fulfill the terms of the agreement.

These rules are intended to implement Iowa Code section 314.28.

[Filed 1/16/03, Notice 11/13/02—published 2/5/03, effective 3/12/03]
[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]
[Filed 6/12/08, Notice 4/23/08—published 7/2/08, effective 8/6/08]

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VETERANS AFFAIRS, IOWA DEPARTMENT OF[801]

Created by 1992 Iowa Acts, chapter 1140, section 8
[Prior to 8/21/91, see Veterans Affairs Department[841]]
[Prior to 1/6/93, see Veterans Affairs Division[613]]

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COUNTY GRANT PROGRAM FOR VETERANS

801—12.1(82GA,SF2425) Purpose. 2008 Iowa Acts, Senate File 2425, section 4, subsection 3, enacts the county grant program for veterans. The purpose and legislative intent of this grant program is to improve delivery of services by the various county commissions of veteran affairs to veterans in their respective counties. Grants will be awarded annually to counties pursuant to an appropriation by the general assembly to the Iowa department of veterans affairs to fund this program.

801—12.2(82GA,SF2425) Grant amounts. The Iowa department of veterans affairs shall award grants in amounts up to a maximum of $10,000 to each county submitting an application that is approved by the department. In order to qualify for a grant, a county must agree to expend the amount of the approved grant on providing services to living veterans and must agree to maintain its current level of spending.

801—12.3(82GA,SF2425) Application procedure. Counties that wish to apply for a grant shall submit an application provided by the department to the Iowa Department of Veterans Affairs, Camp Dodge, Building A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131. Applications will be accepted up to May 15 of each year for a June 1 approval. Applications received after May 15 will be approved strictly on an emergency basis in cases in which the applying county has an identified need and distributed funds will be expended before the end of the fiscal year. Once the grant funding appropriated by the general assembly has been expended, the department will compile a list of grant applications, based on the date of receipt, for future approval if supplemental funding is provided. The application shall contain the following:

12.3(1) *Application summary.* The application summary shall consist of a brief description of the proposed project and the signatures of a member of the board of supervisors and a member of the county veteran affairs commission.

12.3(2) *Narrative.* The narrative shall explain the proposed project for which the funds will be used. The narrative must address the assessment factors listed in rule 801—12.4(82GA,SF2425). The assessment factors may be addressed in any sequence that is logical for the proposed project, but all factors should be identified and addressed. Any factors that are not addressed in the application may result in a reduced opportunity for funding of the project.

12.3(3) *Proposed budget.* The budget for the project shall be developed for the fiscal year in which the grant will be received. Beginning with the fiscal year 2008 grant program, recipients must expend grant funds during the fiscal year in which the grant was received. Funding for subsequent years shall be dependent upon future legislative appropriations. Beginning with the fiscal year 2009 grant program, grants may be awarded to supplement county spending on veterans affairs, but shall not supplant the previous year's expenditures. County maintenance of effort will be required, and the application should include the county commission of veteran affairs' budget and actual spending for the previous fiscal year, along with the proposed budget for the fiscal year in which the grant application is being made. Grant funding received from the Iowa department of veterans affairs shall not be included in the county's previous fiscal year expenditures for maintenance of effort purposes. For example, a county with a commission of veteran affairs budget of $20,000 and actual expenditures of $17,000 in fiscal year 2008 will be required to spend $17,000 in fiscal year 2009 in order to meet the maintenance of effort requirement.

12.3(4) *Letters of intent.* If the proposed project involves additional funding from other sources, letters of intent to support the project are required from those additional sources.

801—12.4(82GA,SF2425) Assessment of applications. The Iowa department of veterans affairs will make decisions on applications based upon the following factors:

12.4(1) *Need.* The needs of the local veteran population that currently are not being addressed or that are not being addressed adequately are clearly identified.

12.4(2) *Goals.* The goals of the project are clearly outlined, and the sources of the services to be provided are clearly identified.

12.4(3) *Results.* A tentative time line for the delivery of the proposed services is included along with clearly identified quantitative measurements that will be used to determine the success of the grant in addressing the identified needs.

12.4(4) *Innovation.* The project addresses the implementation of new practices and methods for addressing the needs of the veteran community and improvement of delivery of services.

12.4(5) *Accountability and project monitoring.* The application demonstrates financial accountability and provides mechanisms to ensure proper evaluation of the project.

801—12.5(82GA,SF2425) Application decision. The director of the Iowa department of veterans affairs shall notify each county that submits an application of the department's decision regarding the county's application. An explanation of the reasons for the rejection of a project application and suggestions for improvement shall accompany application denials.

801—12.6(82GA,SF2425) Grant agreement. Each county that is awarded a grant will be required to enter into an agreement with the Iowa department of veterans affairs that specifies the reporting requirements. A written report shall be submitted to the department and shall be due 30 days following the end of the fiscal year in which the grant was received. The report shall provide an assessment of the project, including measurable outcomes such as increased opportunities to publicize veterans' benefits, the number of outreach visits conducted to allow veterans to apply for benefits, the number of applications for benefits filed as a direct result of the project, and increased opportunities for veteran involvement in local veterans' organizations. The report should also contain a final report on county spending for the fiscal year in which the grant was awarded.

801—12.7(82GA,SF2425) Appeals. Applicants that are dissatisfied with the decision of the Iowa department of veterans affairs may file an appeal with the Iowa commission of veterans affairs. The written appeal must be received within 15 working days of the date of the notice of decision; must be based on a contention that the process was conducted outside of statutory authority, violated state or federal law, policy or rules, did not provide adequate public notice, was altered without adequate public notice, or involved conflicts of interest by staff; and must include a request that the commission review the decision and the reasons for the appeal.

The Iowa commission of veterans affairs shall review the appeal at its next regularly scheduled meeting and shall issue a final decision.

801—12.8(82GA,SF2425) Recovery of funds. The treasurer of the state of Iowa shall be the entity charged with the recovery of grant funding from counties in the following circumstances:

12.8(1) *Unspent funds.* Counties not expending the entire amount of the grant by the end of the fiscal year in which the grant was received will be required to return the unspent portion to the state of Iowa.

12.8(2) *Unauthorized use.* Counties expending a portion of the grant on items that do not provide services to living veterans, or the immediate family of a veteran, will be required to return the unauthorized funds to the state of Iowa.

12.8(3) *Maintenance of effort.* Counties not maintaining their previous fiscal year's spending levels will have been seen as supplanting county funding with state grant funds. Counties not complying with their maintenance of effort will be required to return the supplanted portion to the state of Iowa.

These rules are intended to implement 2008 Iowa Acts, Senate File 2425, section 4, subsection 3.

[Filed emergency 1/29/07—published 2/28/07, effective 1/29/07]
[Filed emergency 10/12/07—published 11/7/07, effective 10/12/07]
[Filed emergency 6/10/08—published 7/2/08, effective 6/10/08]

CHAPTER 13
VIETNAM CONFLICT VETERANS BONUS

801—13.1(35A) Bonus for persons serving in the Vietnam service area.

13.1(1) *Service requirement.* A person serving in the Vietnam service area is a person who served on active duty for not less than 120 days in the armed forces of the United States, and who served at any time between July 1, 1973, and May 31, 1975, both dates inclusive, and who at the time of entering into active duty service was a legal resident of the state of Iowa, and who had maintained the person's residence in this state for a period of at least six months immediately before entering into active duty service, and was honorably discharged or separated from active duty service, or is still in active service in an honorable status, or has been retired, or has been furloughed to a reserve, or has been placed on inactive status and was on active duty service in the Vietnam service area, within the dates specified in this subrule, if the veteran earned either a Vietnam service medal or an armed forces expeditionary medal Vietnam or can otherwise establish service in the Vietnam service area during that period.

13.1(2) *Compensation.* Compensation for persons who served in the Vietnam service area shall be as follows:

a. The amount of compensation shall be the sum of $17.50 for each month that the person was on active duty service in the Vietnam service area, within the dates specified in subrule 13.1(1).

b. In addition, the person shall receive compensation at the sum of $12.50 for each month that the person was on active duty service within the dates specified in subrule 13.1(1) and was not in the Vietnam service area. For example, a person who served six months in the Vietnam service area and six months not in the Vietnam service area will receive compensation for six months at $17.50 per month, which is $105, and six months at $12.50 per month, which is $75, for a total compensation payment of $180.

c. Compensation under this subrule shall not exceed a total sum of $500. Compensation for a fraction of a month shall not be considered unless the fraction is 16 days or more, in which case the fraction shall be computed as a full month.

801—13.2(35A) Bonus for persons serving outside the Vietnam service area.

13.2(1) *Service requirement.* A person serving outside the Vietnam service area is a person otherwise qualified under subrule 13.1(1) except that the person did not earn either a Vietnam service medal or an armed forces expeditionary medal Vietnam and did not serve in the Vietnam service area during the period between July 1, 1973, and May 31, 1975, both dates inclusive.

13.2(2) *Compensation.* Compensation shall be the sum of $12.50 for each month that the person was on active duty service within the dates specified in subrule 13.2(1). Compensation under this subrule shall not exceed a total sum of $300. Compensation for a fraction of a month shall not be considered unless the fraction is 16 days or more, in which case the fraction shall be computed as a full month.

801—13.3(35A) Other Vietnam veterans compensation.

13.3(1) *Compensation from other states.* A person is not entitled to compensation pursuant to this chapter if the person received from another state a bonus or compensation similar to that provided in this chapter.

13.3(2) *Compensation from previous bonus.* The maximum compensation a person may receive pursuant to this chapter shall be reduced by the amount of any Vietnam veterans bonus received from this state by that person for service prior to July 1, 1973. For example, if a veteran received compensation under the Vietnam veterans bonus authorized in 1973 Iowa Acts, House File 656, for service between July 1, 1958, and June 30, 1973, that compensation would be subtracted from the maximum amount permitted under this chapter in order to determine the amount of compensation the veteran may receive under this chapter. If the veteran received the maximum amount permitted, no compensation is payable under this chapter.

801—13.4(35A) Definition of active duty. "Active duty" means full-time duty in the armed forces of the United States, excluding active duty for training purposes only and excluding any period a person was assigned by the armed forces to a civilian institution for a course of education or training which was substantially the same as established courses offered to civilians, or as a cadet or midshipman, however enrolled, at one of the service academies.

801—13.5(35A) Survivor compensation. The surviving unremarried widow or widower, child or children, mother, father, or person standing in loco parentis, in the order named and none other, of any deceased person shall be paid the compensation that the deceased person would be entitled to pursuant to this chapter, if living.

However, if any person has died or shall die, or is disabled, from service-connected causes incurred during the period and in the area from which the person is entitled to receive compensation pursuant to this chapter, the person or the first survivor as designated by this rule, and in the order named, shall be paid $500 or $300, whichever maximum amount would have applied pursuant to rule 801—13.1(35A) or 801—13.2(35A), regardless of the length of service.

801—13.6(35A) Persons not eligible for compensation. A person is not entitled to compensation pursuant to this chapter if the person was on active duty service after July 1, 1973, and the person refused to be subject to military discipline on conscientious, political, religious, or other grounds.

801—13.7(35A) Penalties. A person who knowingly makes a false statement relating to a material fact in supporting an application under this chapter is guilty of a serious misdemeanor. A person convicted under Iowa Code section 35A.8 as amended by 2007 Iowa Acts, Senate File 578, section 1, subsection 5c, shall forfeit all benefits to which the person may have been entitled under this chapter.

801—13.8(35A) Tax exemption. All payments and allowances made under this chapter shall be exempt from taxation, levy, and sale on execution.

801—13.9(35A) Application procedures and determination of eligibility.

13.9(1) *Application procedures.* Application shall be made on forms provided by the Iowa department of veterans affairs. Applications may be obtained from the department at the address listed in subrule 13.9(4) or from the department's Web site at www.iowava.org. The applicant shall provide the information requested on the application and include any additional documentation required (for example, a copy of the applicant's DD Form 214). The completed application, including documentation, shall be returned to the department at the address listed in subrule 13.9(4).

13.9(2) *Department processing and investigation.* The executive director of the Iowa department of veterans affairs will approve or disapprove the application.

13.9(3) *Appeals procedure.* Decisions of the executive director are subject to review by the commission pursuant to 801—Chapter 8, Contested Cases. Applicants may appeal the decisions of the commission as provided by Iowa Code section 17A.19.

13.9(4) *Office address.* Persons may contact the Iowa department of veterans affairs at Camp Dodge, Bldg. A6A, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824; telephone (515)242-5331 or 1-800-838-4692; fax (515)242-5659. The department's Web address is www.iowava.org.

801—13.10(35A) Bonus restrictions and limitations. All bonuses under the program are subject to funding availability. Bonuses will be awarded in the order in which completed applications are received.

These rules are intended to implement Iowa Code Supplement section 35A.8(5) as amended by 2008 Iowa Acts, House File 2700, section 36.

[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]
[Filed emergency 6/11/08—published 7/2/08, effective 6/11/08]

CHAPTER 8
SUBSTANTIVE AND INTERPRETIVE RULES

[Prior to 9/24/86 see Industrial Commissioner[500]]
[Prior to 1/29/97 see Industrial Services Division[343]]
[Prior to 7/29/98 see Industrial Services Division[873]Ch 8]

876—8.1(85) Transportation expense. Transportation expense as provided in Iowa Code sections 85.27 and 85.39 shall include but not be limited to the following:

1. The cost of public transportation if tendered by the employer or insurance carrier.
2. All mileage incident to the use of a private auto. The per-mile rate for use of a private auto from August 1, 2005, through June 30, 2006, shall be 40.5 cents. For annual periods beginning July 1, 2006, and thereafter, the per-mile rate shall be the rate allowed by the Internal Revenue Service for the business standard mileage rate in effect on July 1 of each year.
3. Meals and lodging if reasonably incident to the examination.
4. Taxi fares or other forms of local transportation if incident to the use of public transportation.
5. Ambulance service or other special means of transportation if deemed necessary by competent medical evidence or by agreement of the parties.

Transportation expense in the form of reimbursement for mileage which is incurred in the course of treatment or an examination, except under Iowa Code section 85.39, shall be payable at such time as 50 miles or more have accumulated or upon completion of medical care, whichever occurs first. Reimbursement for mileage incurred under Iowa Code section 85.39 shall be paid within a reasonable time after the examination.

The workers' compensation commissioner or a deputy commissioner may order transportation expense to be paid in advance of an examination or treatment. The parties may agree to the advance payment of transportation expense.

This rule is intended to implement Iowa Code sections 85.27 and 85.39.

876—8.2(85) Overtime. The word "overtime" as used in Iowa Code section 85.61 means amounts due in excess of the straight time rate for overtime hours worked. Such excess amounts shall not be considered in determining gross weekly wages within Iowa Code section 85.36. Overtime hours at the straight time rate are included in determining gross weekly earnings.

This rule is intended to implement Iowa Code sections 85.36 and 85.61.

876—8.3 Rescinded, effective July 1, 1982.

876—8.4(85) Salary in lieu of compensation. The excess payment made by an employer in lieu of compensation which exceeds the applicable weekly compensation rate shall not be construed as advance payment with respect to either future temporary disability, healing period, permanent partial disability, permanent total disability or death.

This rule is intended to implement Iowa Code sections 85.31, 85.34, 85.36, 85.37 and 85.61.

876—8.5(85) Appliances. Appliances are defined as hearing aids, corrective lenses, orthodontic devices, dentures, orthopedic braces, or any other artificial device used to provide function or for therapeutic purposes.

Appliances which are for the correction of a condition resulting from an injury or appliances which are damaged or made unusable as a result of an injury or avoidance of an injury are compensable under Iowa Code section 85.27.

876—8.6(85,85A) Calendar days—decimal equivalent. Weekly compensation benefits payable under Iowa Code chapters 85 and 85A are based upon a seven-day calendar week. Each day of weekly compensation benefits due may be paid by multiplying the employee's weekly compensation benefit rate by the decimal equivalents of the number of days as follows:

1 day	= .143	×	weekly rate
2 days	= .286	×	weekly rate
3 days	= .429	×	weekly rate

4 days = .571 × weekly rate
5 days = .714 × weekly rate
6 days = .857 × weekly rate

This rule is intended to implement Iowa Code sections 85.31, 85.33 and 85.34.

876—8.7(86) Short paper. All filings before the workers' compensation commissioner shall be on white paper measuring 8½ inches by 11 inches.

This rule is intended to implement Iowa Code section 86.18.

876—8.8(85,17A) Payroll tax tables. Tables for determining payroll taxes to be used for the period July 1, 2008, through June 30, 2009, are the tables in effect on July 1, 2008, for computation of:

1. Federal income tax withholding according to the percentage method of withholding for weekly payroll period. (Internal Revenue Service, Circular E, Employer's Tax Guide, Publication 15 [2008].)
2. Iowa Withholding Tax Guide. (Iowa Department of Revenue Iowa Withholding Tax Rate Tables [Effective April 1, 2006].)
3. Social Security and Medicare withholding (FICA) at the rate of 7.65 percent. (Internal Revenue Service, Circular E, Employer's Tax Guide, Publication 15 [2008].)

This rule is intended to implement Iowa Code section 85.61(6).

876—8.9(85,86) Exchange of records. Whether or not a contested case has been commenced, upon the written request of an employee or the representative of an employee who has alleged an injury arising out of and in the course of employment, an employer or insurance carrier shall provide the claimant a copy of all records and reports in its possession generated by a medical provider.

Whether or not a contested case has been commenced, upon the written request of the employer or insurance carrier against which an employee has alleged an injury arising out of and in the course of employment, the employee shall provide the employer or insurance carrier with a patient's waiver. See rules 876—3.1(17A) and 876—4.6(85,86,17A) for the waiver form used in contested cases. Claimant shall cooperate with the employer and insurance carrier to provide patients' waivers in other forms and to update patients' waivers where requested by a medical practitioner or institution.

A medical provider or its agent shall furnish an employer or insurance carrier copies of the initial as well as final clinical assessment without cost when the assessments are requested as supporting documentation to determine liability or for payment of a medical provider's bill for medical services. When requested, a medical provider or its agent shall furnish a legible duplicate of additional records or reports. Except as otherwise provided in this rule, the amount to be paid for furnishing duplicates of records or reports shall be the actual expense to prepare duplicates not to exceed: $20 for 1 to 20 pages; $20 plus $1 per page for 21 to 30 pages; $30 plus $.50 per page for 31 to 100 pages; $65 plus $.25 per page for 101 to 200 pages; $90 plus $.10 per page for more than 200 pages, and the actual expense of postage. No other expenses shall be allowed.

EXAMPLE 1. For 7 pages of records the amount to be paid for furnishing duplicates shall not exceed $20.

EXAMPLE 2. For 28 pages of records the amount to be paid for furnishing duplicates shall not exceed $28 ($20 plus (8 times $1)).

EXAMPLE 3. For 41 pages of records the amount to be paid for furnishing duplicates shall not exceed $35.50 ($30 plus (11 times $.50)).

EXAMPLE 4. For 127 pages of records the amount to be paid for furnishing duplicates shall not exceed $71.75 ($65 plus (27 times $.25)).

EXAMPLE 5. For 210 pages of records the amount to be paid for furnishing duplicates shall not exceed $91 ($90 plus (10 times $.10)).

This rule is intended to implement Iowa Code sections 85.27, 85.31, 85.33 to 85.37, 85.39, 85.61, 86.8, 86.10, 86.18 and 86.39.

876—8.10(85B) Apportionment of age-related loss for occupational hearing loss claims.

8.10(1) *Effective date.* This rule is effective for claims for occupational hearing loss filed on or after July 1, 1998.

8.10(2) *Purpose.* The purposes of this rule are to adopt tables and the method for calculating age-related hearing loss and to adopt a worksheet for apportionment of age-related hearing loss for occupational hearing loss claims.

8.10(3) *Table.* In 1972 the National Institute for Occupational Safety and Health (NIOSH) published the Criteria for a Recommended Standard: Occupational Exposure to Noise (NIOSH Publication No.73-11001). Table B-1, page I-16, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Males and Table B-2, page I-17, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Females. These NIOSH tables are used to calculate the correction value for age for males and females for 500, 1000, 2000 and 3000 hertz.

For example, the age correction for a male 21 years of age is 10 decibels at 500 hertz, 5 decibels at 1000 hertz, 3 decibels at 2000 hertz and 4 decibels at 3000 hertz. The correction for age is 5.50 decibels (the sum of 10+5+3+4 divided by 4).

The following table is to be used to determine an employee's age-related change in hearing level during the period of employment. To determine the age-related change in hearing level in decibels during the period of employment, subtract the value shown in the table for the employee's age at the beginning of employment from the value shown in the table for the employee's age on the date of injury.

NOTE: This table should not be used to compute standard threshold shift as required by rules of the Occupational Safety and Health Administration or Iowa occupational safety and health administration.

Age in Years	Correction in dB	
	Males	Females
20 or younger	5.50	7.25
21	5.50	7.75
22	5.50	7.75
23	5.50	8.00
24	5.75	8.00
25	6.00	8.25
26	6.25	8.50
27	6.50	8.75
28	6.75	8.75
29	6.75	8.75
30	6.75	9.00
31	7.25	9.25
32	7.50	9.50
33	7.50	9.75
34	7.75	9.75
35	8.00	10.00
36	8.25	10.25
37	8.75	10.25
38	8.75	10.50
39	9.00	11.00
40	9.00	11.00
41	9.25	11.25
42	10.00	11.50
43	10.25	11.75
44	10.25	12.00
45	10.50	12.25
46	10.75	12.50
47	11.00	12.50

Age in Years	Correction in dB	
	Males	Females
48	11.50	13.00
49	12.00	13.25
50	12.25	13.50
51	12.25	13.75
52	12.75	13.75
53	13.25	14.25
54	13.50	14.50
55	14.00	15.00
56	14.25	15.00
57	14.50	15.25
58	15.25	15.75
59	15.50	16.00
60 or older	16.00	16.25

8.10(4) *Apportionment.* The apportionment of age-related hearing loss shall be made by reducing the total binaural percentage hearing loss as calculated pursuant to Iowa Code section 85B.9(3) by the same percentage as the decibels of age-related change in hearing level occurring during the period of employment bears to the total decibel hearing level in each ear.

Age-related hearing loss is apportioned using the results of the audiogram determined to be the proper audiogram for measurement of the employee's hearing loss on the date of injury by using the following steps:

1. Separately for each ear, compute the average of the employee's decibel hearing levels at 500, 1000, 2000, and 3000 hertz for that ear.
2. Separately for each ear, compute the percentage loss for each ear.
3. Compute the employee's age-related change in hearing level in decibels during the period of employment using the table in subrule 8.10(3).
4. Separately for each ear, divide the result of step 3 by the result of step 1 to compute the age-correction factor for that ear.
5. Separately for each ear, multiply the total percentage hearing loss in that ear calculated pursuant to Iowa Code section 85B.9 by the age-correction factor for that ear.
6. Separately for each ear, subtract the result obtained in step 5 from the total percentage hearing loss in that ear to obtain the age-corrected hearing loss for that ear.
7. Multiply the age-corrected hearing loss in the better ear as calculated in step 6 by 5 and add the percentage hearing loss in the worse ear.
8. Divide the result obtained in step 7 by 6 to obtain the age-corrected binaural percentage hearing loss.

8.10(5) *Worksheet.* The following worksheet is used to calculate the percentage of age-corrected binaural hearing loss.

APPORTIONMENT OF PERCENT HEARING LOSS FOR AGE

	Left Ear Hearing Level	Frequency in Hertz	Right Ear Hearing Level
1.	_____	500	_____
2.	_____	1000	_____
3.	_____	2000	_____
4.	_____	3000	_____
5.	_____	total of lines 1 through 4	_____
	divide by 4	(divide the "total" by 4)	divide by 4
6.	_____	equals average equals	_____
	minus 25	subtract "low fence"	minus 25

7.	_____	equals "Excess"	_____
	multiply by 1.5	multiply % factor	multiply by 1.5
8.	_____	equals % loss each ear	_____
	(% loss left ear)		(% loss right ear)
9.	Age on date of injury	____	
10.	Age at beginning of employment	____	
11.		____	correction for age on date of injury in dB from table
			minus
12.		____	correction for age at beginning of employment in dB from table
			equals
13.		____	age-related change in hearing level during employment in dB

LEFT EAR		RIGHT EAR
	Divide age-related change in hearing level from line 13 by average hearing level from line 6	
	To obtain	
14. _____	age correction factor	_____
	multiply % loss from line 8 by age-correction factor from line 14	
	To obtain	
15. _____	deduction for age-correction	_____
	subtract line 15 from line 8	
	To obtain	
16. _____	age-corrected percent hearing loss	_____

BINAURAL PERCENTAGE LOSS

17. _____	% loss better ear (smaller amount) from line 16, multiplied by 5
	plus

18. _____		% loss worse ear (larger amount) from line 16
19. _____		equals
	divided by 6	
		equals
20. _____		% age-corrected binaural hearing loss

This rule is intended to implement Iowa Code sections 85B.9A and 86.8.

[Filed emergency 6/25/76—published 7/12/76, effective 7/1/76]
[Filed 8/3/77, Notice 6/29/77—published 8/24/77, effective 9/28/77]
[Filed 9/26/80, Notice 8/20/80—published 10/15/80, effective 11/19/80]
[Filed emergency 6/18/82—published 7/7/82, effective 7/1/82]
[Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]
[Filed emergency 6/22/84—published 7/18/84, effective 7/1/84]
[Filed emergency 5/31/85—published 6/19/85, effective 7/1/85]
[Filed 9/4/85, Notice 7/31/85—published 9/25/85, effective 10/30/85]
[Filed emergency 6/13/86—published 7/2/86, effective 7/1/86]
[Editorially transferred from [500] to [343] IAC Supp. 9/24/86]
[Filed emergency 5/22/87—published 6/17/87, effective 7/1/87]
[Filed emergency 5/31/88—published 6/29/88, effective 7/1/88]
[Filed emergency 5/12/89—published 5/31/89, effective 7/1/89]
[Filed emergency 5/31/90—published 6/27/90, effective 7/1/90]
[Filed emergency 7/1/91—published 7/24/91, effective 7/1/91]
[Filed emergency 6/5/92—published 6/24/92, effective 7/1/92]
[Filed 8/13/92, Notice 6/24/92—published 9/2/92, effective 10/7/92]
[Filed 8/13/92, Notice 7/8/92—published 9/2/92, effective 10/7/92]
[Filed emergency 5/21/93—published 6/9/93, effective 7/1/93]
[Filed emergency 6/3/94—published 6/22/94, effective 7/1/94]
[Filed 1/13/95, Notice 12/7/94—published 2/1/95, effective 3/8/95][1]
[Filed emergency 5/10/95—published 6/7/95, effective 5/17/95]
[Filed emergency 7/7/95—published 8/2/95, effective 7/7/95]
[Filed 4/3/96, Notice 2/14/96—published 4/24/96, effective 7/1/96]
[Filed emergency 6/11/96—published 7/3/96, effective 7/1/96]
[Filed 1/10/97, Notice 12/4/96—published 1/29/97, effective 3/5/97]
[Filed emergency 6/17/97—published 7/16/97, effective 7/1/97]
[Filed 5/1/98, Notice 3/25/98—published 5/20/98, effective 6/24/98]
[Filed emergency 6/23/98—published 7/15/98, effective 7/1/98]
[Filed emergency 6/30/98—published 7/29/98, effective 7/1/98]
[Filed emergency 7/1/98—published 7/29/98, effective 7/1/98]
[Filed 1/5/99, Notice 7/29/98—published 1/27/99, effective 3/3/99]
[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]
[Filed 5/12/00, Notice 4/5/00—published 5/31/00, effective 7/5/00]
[Filed emergency 6/22/00—published 7/12/00, effective 7/1/00][◊]
[Filed 8/17/00, Notice 7/12/00—published 9/6/00, effective 10/11/00]
[Filed emergency 6/20/01—published 7/11/01, effective 7/1/01]
[Filed 2/15/02, Notice 1/9/02—published 3/6/02, effective 4/10/02]
[Filed emergency 4/12/02—published 5/1/02, effective 7/1/02]
[Filed emergency 6/30/03—published 7/23/03, effective 7/1/03]
[Filed emergency 6/11/04—published 7/7/04, effective 7/1/04]
[Filed emergency 6/27/05—published 7/20/05, effective 7/1/05]
[Filed emergency 7/27/05—published 8/17/05, effective 8/1/05]

[Filed 11/4/05, Notice 9/14/05—published 11/23/05, effective 1/1/06]
[Filed emergency 6/28/06—published 7/19/06, effective 7/1/06]
[Filed emergency 6/15/07—published 7/18/07, effective 7/1/07]
[Filed emergency 6/10/08—published 7/2/08, effective 7/1/08]

◊ Two or more ARCs

1 Effective date of 343—8.9(85,86), second unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held February 13, 1995; delay lifted by this Committee May 9, 1995.

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