

November 4, 2019

DHS Council Members:

Enclosed please find the materials for our upcoming Council meeting. This meeting will be held at the Hoover State Office Building on Wednesday, November 13, 2019.

Please let me know if you will be in attendance or have any questions.

I look forward to seeing all of you on November 13, 2019.

Thank you,

Julie Dougherty
Council Secretary
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HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

The Human Services Department amends Chapter 77, "Conditions Of Participation For Providers Of Medical And Remedial Care," Chapter 78, "Amount, Duration And Scope Of Medical And Remedial Services," and Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.3.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.3.

Purpose and Summary

The Department is clarifying the brain injury (BI) waiver provider qualifications to align with the services and supports that are rendered by qualified brain injury professionals and accredited brain injury rehabilitation programs. The Department began evaluating core standardized assessments for the BI waiver in 2011 as part of the Balancing Incentive Payment Program (BIPP), and the Iowa Medicaid Enterprise (IME) adopted the interRAI Home Care Assessment Tool for the purposes of determining level of care for BI waiver eligibility. The Department adopted this tool recognizing that an additional or alternative tool would need to be identified which would address the cognitive disabilities related to brain injury. The primary goal of moving forward with adoption of the most current version of the Mayo-Portland Adaptability Inventory Scale is to fulfill the purposes of a valid and appropriate assessment of need, possible allocation of resources and comprehensive community-based, person-centered service planning for both the HCBS brain injury waiver and the community-based neurobehavioral rehabilitation service.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on August 28, 2019, as **ARC 4628C**.

No public comments were received.

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on November 13, 2019.

Fiscal Impact

This rule making has a fiscal impact of \$100,000 annually or \$500,000 over 5 years to the state of Iowa. The fiscal impact for Family Training and Counseling and Behavior Programming providers cannot be determined at this time because the number of new providers that will enroll and the number of members that will access the service is not known.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on December 11, 2019.

The following rule-making action is adopted:

ITEM 1. Adopt the following new paragraph 77.39(21)"f":

f. Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

ITEM 2. Adopt the following new subparagraphs 77.39(23)"b"(6) and (7):

(6) Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

(7) Individuals who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

ITEM 3. Amend subrule 77.52(3) as follows:

77.52(3) Provider standards. All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) to (3) No change.

(4) The program administrator shall be a certified brain injury specialist trainer (CBIST) certified through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator's absence.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. to 3. No change.

4. Be a certified brain injury specialist (CBIS) certified through the Academy for the Certification of Brain Injury Specialists (ACBIS) or have other nationally recognized brain injury certification as approved by the department.

(6) No change.

b. No change.

c. Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) training certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by ~~441—subparagraph 78.54(3)“a”(6) subparagraph 77.52(3)“a”(6).~~

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBISs certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

f. to j. No change.

k. The organization shall implement the following outcome-based standards for rights and dignity:

(1) to (4) No change.

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with ~~481—subrule 63.23(4), rule 481—63.33(135C), and rule 481—63.37(135C)~~ rules 481—63.21(135C), 481—63.27(135C), and 481—63.28(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

l. to 8. No change.

(6) to (11) No change.

ITEM 4. Amend subrule 78.56(2) as follows:

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. to c. No change.

d. *Needs assessment.* The member shall have a ~~standardized comprehensive functional neurobehavioral assessment reviewed or~~ an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a licensed neuropsychologist, neurologist, M.D., or D.O. qualified trained assessor. The ~~neurobehavioral~~ assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member's managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. *Standards for assessment.* Each member will have had a ~~department-approved, standardized comprehensive functional neurobehavioral~~ the MPAI assessment completed within the 90 days prior to admission. ~~Each~~ In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury, ~~which~~ and must include the following:

(1) to (10) No change.

f. No change.

ITEM 5. Amend rule ~~441—83.81(249A)~~, definition of “Qualified brain injury professional,” as follows:

“*Qualified brain injury professional*” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

ITEM 6. Amend paragraph ~~83.82(1)“F”~~ as follows:

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC), Form 470-4694, and Form 470-5572, the Mayo-Portland Adaptability Inventory (MPAI), are available on request from the member's managed care organization or the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

ITEM 7. Amend subrule 83.82(4) as follows:

83.82(4) Securing a state payment slot.

a. to c. No change.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an intermediate care facility for persons with an intellectual disability (ICF/ID), a skilled nursing facility, or an ICF and have resided in that setting for six or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department shall reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state on July 1, 2019, and for all new applications received on or after July 1, 2019. Applicants may request an emergency need reserved capacity slot by submitting the completed Home- and Community-Based Services (HCBS) Brain Injury Waiver Emergency Need Assessment, Form 470-5583, to the IME medical services unit.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(4) "e"(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.82(4) "e"(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall remain on the waiting list, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new emergency needs assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist	Telephone Number 256-4653	Email Address lmoskow@dhs.state.ia.us
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1. Give a brief summary of the rule changes:

The proposed rule amends Iowa Admin Code 441-77

- Updates the providers that are eligible to participate in the Brain Injury Waiver as Family Training and Counseling and Behavior Programming providers.
- Adopts the current version of the Mayo Portland Adaptability Inventory as a supplement to the interRAI-HC for the purposes of BI Waiver level of care determination, comprehensive person-centered service planning and measuring individual member service outcomes.
- Adds an additional requirement for the CNRS Administrator to be present for a specific amount of time in the service location
- Clarifies the training and certification expectations for CNRS direct care staff.
- Formalizes the most current version of the Mayo Portland Adaptability Inventory as the required standardized assessment for Community-based Neurobehavioral Rehabilitation.
- Makes two technical corrections to incorrect rule citations.
- Adding the reserved capacity slot criteria for the BI Waiver.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Section 249A.15A, Code 2018

3. What is the reason for the Department requesting these changes?

The Department is clarifying the BI Waiver provider qualifications to align with the services and supports that are being rendered by Qualified Brain Injury Professionals and accredited brain injury rehabilitation programs

The Department began evaluating core standardized assessments for the BI Waiver in 2011, as part of the Balancing Incentive Payment Program (BIPP), the IME adopted the InterRAI Home Care Assessment Tool for the purposes of determining level of care for BI Waiver eligibility. The department adopted this tool recognizing that an additional or alternative tool would need to be identified which would address the cognitive disabilities related to brain injury.

The primary goal of moving forward with adoption of the most current version of the Mayo Portland Adaptability Inventory Scale is to fulfill the purposes of a valid and appropriate assessment of need, possible allocation of resources and comprehensive community-based person-centered service planning for both the HCBS Brain Injury Waiver and the Community-Based Neurobehavioral Rehabilitation service.

4. What will be the effect of this rule making (who, what, when, how)?

Adoption of the Mayo-Portland Adaptability Inventory will:

- assist service providers in the clinical evaluation of people during the post-acute (post-hospital) period following acquired brain injury (ABI),
- assist the Department in the evaluation of rehabilitation programs designed to serve people with brain injury, and
- assist the Department to better understand the outcomes of acquired brain injury (ABI) services, and
- assist service providers with comprehensive service planning to assure the appropriate scope, duration, and intensity of service delivery.

5. Is the change mandated by State or Federal Law?

No.

6. Will anyone be affected by this rule change? If yes, who will be affected and will it be to the person's (organization's) benefit or detriment?

Yes, Brain Injury Waiver members and applicants to the Brain Injury Waiver will have an appropriate and reliable clinical evaluation of the physical, cognitive, emotional, behavioral, and social problems that people present after a brain injury. Members may experience additional assessment fatigue by being required to participate in an additional assessment. However, the member's will be better served through the use of a valid and reliable BI assessment tool for service planning.

Medicaid member's identified for Community Based Neurobehavioral Rehabilitation Services (CNRS) will have a standardized, appropriate and reliable clinical evaluation of the physical, cognitive, emotional, behavioral, and social problems that people present after a brain injury.

Providers of post-acute brain injury services will have a reliable means of evaluating the physical, cognitive, emotional, behavioral, and social problems that people present after a brain injury to support and enhance the provider's ability to target interventions and measure individual members' progress in response to those targeted interventions and strategies. Providers not currently using the MPAL-IV will require training on completion of the assessment and the use of the tool in service planning.

Community Based Neurobehavioral Rehabilitation Providers, the Brain Injury Alliance of Iowa, the MHDS Regions and various other HCBS BI Waiver providers throughout the state are utilizing the MPAL-IV for the assessment of individual's need for services and to measure individual progress and service outcomes.

The Department and the MCOs will need to plan for the additional time and cost associated with completing the MPAL.

7. What are the potential benefits of this rule?

The benefits of adoption of the Mayo-Portland Adaptability Inventory will:

- assist service providers in the clinical evaluation of people during the post-acute (post-hospital) period following acquired brain injury (ABI), and
- assist providers to provide more customized services to the BI population, and
- assist the Department in the evaluation of the efficacy of the range of post-acute interventions and rehabilitation services designed to serve people with brain injury, and
- assist the Department to better document and evaluate the outcomes of acquired brain injury (ABI) and ABI services.

8. What are the potential costs, to the regulated community or the state of Iowa as a whole, of this rule?

The MPAI-4 form consists of four pages that contain brief instructions for completing the ratings for each item, the 29 items comprising the MPAI-4, 6 additional items (items 30-35) for recording additional preinjury and post-injury information about the person being evaluated, and the scoring area. The inventory has been translated into French, German, Danish, and Spanish. All materials for the MPAI-4, including the translations, are available for download for free on the web site (www.tbims.org/combi/mpai) for the Center for Outcome Measurement in Brain Injury (COMBI) sponsored by the National Institute of Disability and Rehabilitation Research (NIDRR) through its TBI Model System Program.

The MPAI may be downloaded from the COMBI web site, copied, and used without fee or other charge. Malec, J. (2005). The Mayo Portland Adaptability Inventory. The Center for Outcome Measurement in Brain Injury. <http://www.tbims.org/combi/mpai>

Providers not currently using the tool will have new costs related to training.

The cost of the adoption of the MPAI will be the additional cost to the MCOs and FFS to train assessors and case managers. The MCOs will need to build the new assessment into their care management systems to be able to provide IME with assessment data and other information related to required reporting. All costs will need to be considered for implementing the new assessment of completing the assessment in addition to the interRAI, the state will need to account for these costs in the MCO capitated payment negotiations for the July 1, 2019 Amendment to the IA Health Link contracts and the FFS CSA Contract. MPAI tool is in the public domain, is free to use and only requires approximately 1.5 hours of time to complete the assessment with an additional 15 to 30 minutes to derive the T-score. There is no requirement to purchase licenses for this tool.

9. Do any other agencies regulate in this area? If so, what agencies and what Administrative Code sections apply?

No.

10. What alternatives to direct regulation in this area are available to the agency? Why were other alternatives not used?

One alternative to direct regulation is to continue as status quo solely utilizing the interRAI for BI Waiver level of care, service authorization and service delivery, and provide clarifying guidance in the provider manuals.

A second alternative is to discontinue the use of interRAI for the BI Waiver and replace it entirely with the MPAI; however the MPAI does not identify specific ADL or IADL deficits that are required to determine NF, SNF or ICF/ID Level of Care. The workgroup will address this in Phase 2 of the project.

11. Does this rule contain a waiver provision? If not, why?

A waiver provision is not necessary. 441 -1.8(17A, 217) provides for waiver of administrative rules in exceptional circumstances.

12. What are the likely areas of public comment?

BI Waiver applicants and CNRS participants will be pleased to have a reliable and valid tool used to identify the level of disability related to their physical, cognitive, emotional, behavioral, and social problems associated with brain injury which will enable appropriate services can to be targeted to those specific needs. BI Waiver members and applicants are also likely to comment on the challenge of scheduling the time to participate in two assessments (the interRAI and the MPAI)

The brain injury provider community will be pleased that the Department is adopting a reliable and valid tool to identify the physical, cognitive, emotional, behavioral, and social problems associate with brain injury and provide a means of targeting treatment interventions and strategies for person centered planning consistently across the population.

Managed Care Organizations may be concerned about access to information and/or training on the use of the MPAI. However Iowa has a significant number of professionals who have facility in training on the use of the MPAI including the Brain Injury Alliance of Iowa who have been trained on the use of the MPAI by its author, Dr. James Malec and who serve multiple MHDS regions in contract to administer the MPAI for recommendations on brain injury service scope, duration and intensity.

13. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee)

The jobs impact is unknowable but is anticipated to be minimal.

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.



Administrative Rule Fiscal Impact Statement

Date: 4/15/2019

Agency: Human Services
IAC citation: 441 IAC 77, 78, 83
Agency contact: LeAnn Moskowitz

Summary of the rule:

The proposed rule amends Iowa Admin Code 441:

- Updates the providers that are eligible to participate in the Brain Injury Waiver as Family Training and Counseling and Behavior Programming providers.
- Adopts the current version of the Mayo Portland Adaptability Inventory as a supplement to the interRAI-HC for the purposes of BI Waiver level of care determination, comprehensive person-centered service planning and measuring individual member service outcomes.
- Adds an additional requirement for the CNRS Administrator to be present for a specific amount of time in the service location
- Clarifies the training and certification expectations for CNRS direct care staff.
- Formalizes the most current version of the Mayo Portland Adaptability Inventory as the required standardized assessment for Community-based Neurobehavioral Rehabilitation.
- Makes two technical corrections to incorrect rule citations.
- Adding the reserved capacity slot criteria for the BI Waiver.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
 Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.

Brief explanation:

Fill in the form below if the impact does not fit the criteria above:

- Fiscal impact of \$100,000 annually or \$500,000 over 5 years.

Assumptions:

Family Training and Counseling and Behavior Programming providers - The fiscal impact cannot be determined at this time because the number of new providers that will enroll and the number of members that will access the service is not known.

Mayo Portland Adaptability Inventory for BI Waiver – The MPAI tool is in the public domain, is free to use and only requires approximately 1.5 hours of time to complete the assessment with an additional 15 to 30 minutes to derive the T-score. There is no requirement to purchase licenses for this tool. However, there will be an additional cost to the MCOs and FFS to train assessors and case managers. The MCOs will need to build the new assessment into their care management systems to be able to provide IME with assessment data and other information related to required reporting. All costs will need to be considered for implementing the new assessment and for completing the assessment. The cost per assessment is estimated at \$430 based on current core standardized assessment costs. This cost is applied to the entire BI waiver population in order to estimate cost across both FFS and MCO.

The remaining changes are not expected to have a fiscal impact.

An October 2019 implementation date is assumed.

The Medicaid state match rate is estimated at 39.12 percent in SFY20 and 38.01 percent in SFY21.

Describe how estimates were derived:

There were 1,436 Brain Injury waiver members in March 2019. \$430 per assessment x 1,436 members results in an annual cost of \$617,480. SFY20 costs will be \$463,110 based on the October implementation date.

Estimated Impact to the State by Fiscal Year

	<u>Year 1 (SFY20)</u>	<u>Year 2 (SFY21)</u>
Revenue by each source:		
General fund		
Federal funds	<u>\$281,941</u>	<u>\$382,776</u>
Other (specify):		
TOTAL REVENUE	<u>\$281,941</u>	<u>\$382,776</u>
Expenditures:		
General fund	<u>\$181,169</u>	<u>\$234,704</u>
Federal funds	<u>\$281,941</u>	<u>\$382,776</u>
Other (specify):		
TOTAL EXPENDITURES	<u>\$463,110</u>	<u>\$617,480</u>
NET IMPACT	<u>(\$181,169)</u>	<u>(\$234,704)</u>

_____ This rule is required by state law or federal mandate.

Please identify the state or federal law:

Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
The changes will be covered by existing appropriations.

Fiscal impact to persons affected by the rule:

Providers not currently using the tool will have new costs related to training.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

No fiscal impact anticipated.

Agency representative preparing estimate: Jason Buls

Telephone number: 515-281-5764

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

The Human Services Department adopts Chapter 105, "Juvenile Detention And Shelter Care Homes," Chapter 112, "Licensing And Regulation Of Child Foster Care Facilities," Chapter 114, "Licensing And Regulation Of All Group Living Foster Care Facilities For Children," Chapter 115, "Licensing And Regulation Of Comprehensive Residential Facilities For Children," and Chapter 116, "Licensing And Regulation Of Residential Facilities For Children With An Intellectual Disability," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 234.6.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 234.6.

Purpose and Summary

These amendments remove obsolete elements within the administrative rules, bring better alignment to current practice and implement changes required by federal law.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on August 28, 2019, as **ARC 4629C**.

The Department received written comments from three organizations regarding proposed changes in Chapters 105, 114, and 115. Comments concerned the federal Juvenile Justice Reform Act of 2018 and the elimination of mechanical restrains; staff ratios enacted in 2012 under the federal Prison Rape Elimination Act; fiscal impacts of background checks; burdens of physical and TB tests before employment can occur; potential transfer of responsibility from the Department to the provider; questions if dietary requirements meet by the school lunch program are satisfactory; questions on the rationale to eliminate prime programming; unrestricted access by the Department to electronic records; change in the definition of secured facility; documentation requirements; and questions on the use of the term permanent placement.

The Department received comments from three organizations regarding proposed changes to Chapter 105. Those comments and responses are as follows:

COMMENT:

Item 3: Eliminating "prime programming"

RESPONSE:

DHS has eliminated the definition of "prime programming time" as follows:

Rescind the definitions of "Controlled substances," "Family shelter home" and "Prime programming time" in rule 441—105.1(232).

COMMENT:

Item 8: Amend Administrative Code 105.5.(1)(d) to require a minimum of one staff person awake in each living unit and to ensure a minimum staff/child ratio of 1:16 is maintained in juvenile detention facilities.

RESPONSE:

DHS agrees. The change was made to ensure a 1:16 staff/child ratio is maintained, as follows:

d. Night hours. At night, there shall be a staff person awake in each living unit and making regular visual checks throughout the night. The visual checks shall be made at least every hour in shelter care and every half hour in detention. A log shall be kept of all checks, including the time of the check and any significant observations. The minimum staff-child ratio must be maintained at 1:16 during the overnight shift. ~~There shall be an on-call system which allows backup within minutes for both child care staff and casework personnel.~~

COMMENT: (2comments)

Item 6: "tested for tuberculosis and have had a physical examination within six months prior to hiring" could lead to complications. Currently, if someone from another agency applies and has documentation that they have had a TB test and physical in the last three years (and can produce documentation), we do not need to send them.

RESPONSE:

DHS agrees. This change was made, as follows:

105.3(2) Health of employees. Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties tested for tuberculosis and have had a physical examination within six months prior to hiring, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous 3 years. ~~A statement attesting to these facts shall be secured at the time of employment and filed in the personnel records of the staff person. A new statement shall be secured at least every three years. Physical examinations shall be completed at least every three years thereafter, or whenever circumstances require them more frequently. Evidence of these examinations or tests shall be included in each personnel file. The statement shall be signed.~~ Examinations or tests shall be completed by one of the following:

a. to c. No change

COMMENT:

Item 8: Requiring Coed staff creates staffing challenges, including an agency of potentially needing to specifically post hiring ads for staff of a particular sex in order to meet this requirement. Some staff identify as gender fluid or may be transgender, which adds additional challenges to meeting this requirement.

RESPONSE:

DHS agrees that this particular hardship for agencies can be remedied by striking the sex/gender requirement of staff, as follows:

105.5(1) Number of staff.

a. Generally. A sufficient number of child care or ~~house parent~~ staff shall be on duty at all times so as to provide adequate coverage. The number of staff required will vary depending on the size and complexity of the program. All facilities shall have at least one staff person on duty. ~~Facilities having six or more residents shall have at least two staff persons on duty at all times that children are usually awake and present in the facility.~~ A minimum staff-to-child ratio of one child care worker to five children shall be maintained at all times children are awake and present in the facility and during supervised outings. ~~Coed facilities having more than five residents should have both male and female staff on duty at all times.~~ All child care or house parent staff shall be at least 18 years of age.

COMMENT:

Item 9: This change in rule requires the agency to request information if it has not been sent by DHS.

RESPONSE:

DHS is still responsible for sending the information and has policies and procedures in place to require as such. If the shelter does not receive the information though, the expectation will be that said information is requested. No change to proposed rule.

COMMENT: (2 comments)

Item 12: Agencies using the school lunch program are assumed to be meeting the dietary requirements of these rules.

RESPONSE:

Residents of shelters must have their dietary needs met by the facilities, which may include special requirements as determined by medical personnel and/or dietitians. No change to proposed rule.

COMMENT:

Item 24: Timeframes for placement in shelter are described as 30 days or less, but the new federal expectation is 14 days or less.

RESPONSE:

Agreed that the rule should include a target of 14 days or less, in keeping with the spirit of the Family First Act. DHS is not in agreement that a maximum length of stay not to exceed 45 days should be written into rules. Changes to proposed rules are as follows:

441—105.18(232) Discharge. Children in shelter care should be discharged to, preferably, a permanent placement, or, alternatively, a lower level of care in a family-like setting, at the earliest possible time, preferably within 14 days. The facility shall collaborate with referral workers to assess each child's need for ongoing placement and the reasons for longer stays shall be documented in the child's case file. Children in detention shall be discharged as determined by the court.

COMMENT:

Item 28. Amend paragraph 105.21(1)"d" to eliminate the use of restrains on known pregnant juveniles in order to ensure compliance with Federal Juvenile Justice Reform Act of 2018.

RESPONSE:

DHS agrees and made the amendment to section 16, in order to be in compliance with Federal requirements, as follows:

105.16(3)e. A child known to be pregnant may not be restrained during labor, delivery, and post-partum recovery, unless credible, reasonable grounds exist to believe the detainee presents an immediate and serious threat of hurting herself, staff, or others.

The Department received comments from three organizations regarding changes to Chapter 114. Those comments and responses are as follows:

COMMENT: (2 comments)

Item 48 does indeed have significant fiscal Impact in direct dissonance with the Fiscal Impact statement attached to the Notice of Intended Action.

RESPONSE:

DHS does not anticipate eliminating "prime programming" as increasing fiscal impact. Minimum staff/child ratios are defined in the contract, which are required when youth are present in the program. Contractors are also required to provide staff at the ratio needed to meet needs of youth in the program. Prime Programming has been irregularly defined and not enforceable. Removing this definition creates more flexibility to contractors without compromising safety of children.

COMMENT: General comment that the process of getting fingerprints completed is challenging and impacting the workforce.

RESPONSE:

DHS is aware of the challenges getting fingerprint checks returned in a timely manner. This Administrative Rule is a

result of the federal requirement under the Family First Act and the legislative change to Iowa Code made last session. DHS understands the concerns and is actively working on a solution with the Department of Public Safety to expedite the process.

COMMENT:

Item 57: The language “tested for tuberculosis and have had a physical examination within six months prior to hiring” could lead to complications. Currently, if someone from another agency applies and has documentation that they have had a TB test and physical in the last three years (and can produce documentation), we do not need to send them.

RESPONSE:

DHS agrees. This change was made as follows:

114.7(2) Health of staff. Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties be tested for tuberculosis and have a physical examination within six months prior to hiring. Physical examinations shall be completed every three years thereafter, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous 3 years. A statement attesting to these facts shall be secured at the time of employment and filed in the staff record of the staff person. A new statement shall be secured at least every three years. Evidence of these examinations or tests shall be included in each personnel file. The statement shall be signed examinations or tests shall be completed by one of the following:

- a. to c. No change.

COMMENT:

Item 59. While the amendment to 114.8(2)d takes out the prime programming time and sets the ratio at one to eight staff to client, there is not a subsequent amendment to the corresponding section – 115.4(1) – Number of staff. – where it still states “There shall be at least a one to five staff to child ratio during prime programming time.” Without a definition of prime programming time any longer (Item 48 deletes it), this doesn’t make sense.

RESPONSE:

DHS agrees. This change was corrects in the amendments to chapter 15.

COMMENT:

Item 63: This change in rule requires the agency to request information if it has not been sent by DHS. Language in the rule was modified due to this comment.

RESPONSE:

DHS is still responsible for sending the information and has policies and procedures in place to require as such. If the shelter does not receive the information though, the expectation will be that said information is requested. No change to proposed rule.

COMMENT:

Item 68: Agencies using the school lunch program are assumed to be meeting the dietary requirements of these rules.

RESPONSE:

Residents of shelters must have their dietary needs met by the facilities, which may include special requirements as determined by medical personnel and/or dieticians.

COMMENT:

Item 75: The language allows DHS too much access to information for children who may not even be in the facility due to a DHS contract.

RESPONSE:

The allowable information will be limited to children in the facility as a result of a DHS contract.

In addition, after the rules were noticed if came to the attention of the Department that one of the new noticed rules in Chapter 114 was not aligned with the Iowa Administrative Code. As a result the last sentence in item 96 was struck from 114.24(1)(c) which referenced to Psychiatric Medical Institutions for Children, as defined by Iowa Code Chapter 135H, as that exemption is not allowed.

Comments and responses regarding changes to Chapter 115.

The Department received two written comments from organizations regarding proposed changes in Chapter 115. The comments and responses are as follows:

COMMENT: (2 comments)

Item 59. While the amendment to 114.8(2)d takes out the prime programming time and sets the ratio at one to eight staff to client, there is not a subsequent amendment to the corresponding section – 115.4(1) – Number of staff. – where it still states “There shall be at least a one to five staff to child ratio during prime programming time.” Without a definition of prime programming time any longer (Item 48 deletes it), this doesn’t make sense.

RESPONSE:

DHS agrees that striking language about “prime programming time” in 115.4(1) must occur. This change was made as follows:

d. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff to client ratio during ~~prime programming time~~ all times children are awake and present in the facility and during supervised outings.

COMMENT:

Item 98: The commenter acknowledges only adjudicated delinquent youth can be placed in a locked secure facility and goes on to ask, “Which rule supersedes the other?”

RESPONSE:

Per the commenter’s question, the definition of a secure facility is slightly modified to provide further clarification. It is not clear what other rule the commenter is referencing as it pertains to which rule supersedes, but suffice to say, providers are encouraged to consult DHS when apparent conflicts in rule chapters arise. Proposed definitions of “Comprehensive residential facility” and “Secure facility,” in Chapter 115 are modified as follows:

“Comprehensive residential facility” means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual ~~treatment~~ service plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, and mechanical restraints, ~~and chemical restraints~~ when these controls meet licensing requirements.

“Secure facility” means any comprehensive residential facility which employs, on a regular basis, locked doors or other ~~physical means~~ building characteristics intended to prevent children in care from leaving the facility without authorization. Secure facilities may only be used for children who have been adjudicated delinquent or placed pursuant to provisions of Iowa Code chapter 229.

This rule making was adopted by the Council on Human Services on November 13, 2019.

Fiscal Impact

This rule makes a number of changes, most of which have no fiscal impact. However, federal law changes now require fingerprint checks for group care and shelter care staff. There are fiscal impacts associated with this rule change.

Jobs Impact

The background checks in these licensure or approval standards could prohibit or employment of persons with criminal or abuse histories. the number of potential jobs that would result from implementation are unknown.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on December 11, 2019.

The following rule-making action is adopted:

ITEM 1. Adopt the following new definitions of "Administrator," "Immediate family," "Schedule II medications," "Staff" and "Time out" in rule **441—105.1(232)**:

"*Administrator*," when used for matters related to a certificate of approval or a certificate of license, means the administrator of the division of adult, children and family services.

"*Immediate family*," for the purposes of this chapter, means persons who have a blood or legal relationship with the child.

"*Schedule II medications*" means those controlled substances identified in Iowa Code chapter 124.

"*Staff*" means any person providing care or services to or on behalf of the residents whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

"*Time out*" applies only to shelter care homes and means the temporary and short-term restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control. Staff physically preventing the resident from leaving the time out area would be considered seclusion in control room conditions.

ITEM 2. Amend rule **441—105.1(232)**, definitions of "Administer medication," "Child care worker or house parent" and "Facility," as follows:

"~~Administer medication~~ *Medication management and administration*" means to ~~remove-properly~~ tend to prescription and nonprescription medications, including, but not limited to: properly obtaining and storing medication; removing medication from its storage place; to ensure-ensuring to the extent possible that the child ingests, applies, or uses the appropriate dosage at the appropriate time of day; and ~~to document~~ documenting the dosage and the time and date that the child ingested, applied, or used the medication.

"~~Child care worker or house parent~~" shall mean an individual employed by a facility whose primary responsibility is the direct care of the children in the facility.

"*Facility*" shall mean a county or multicounty "juvenile detention home" or county or multicounty "juvenile shelter care

home” as ~~those terms are defined in Iowa Code section 232.2,~~ and private juvenile detention and shelter care homes as defined in Iowa Code section 232.2 which do not meet the requirements of being “county or multicounty.”

ITEM 3. Rescind the definitions of “Controlled substances,” “Family shelter home” and “Prime programming time” in rule **441—105.1(232)**.

ITEM 4. Rescind subrule 105.2(12) and adopt the following new subrule in lieu thereof:

105.2(12) Private water supplies.

a. Maintenance and operation. Each privately operated water supply shall be maintained and operated in a manner that ensures safe drinking water. Each water supply used as part of a facility shall be annually inspected and evaluated for deficiencies that may allow contaminants access to the well interior. Items such as open or loose well caps, missing or defective well vents, poor drainage around the wells, and the nearby storage of potential contaminants shall be evaluated. All deficiencies shall be corrected by a well contractor certified by the state within 30 days of discovery.

b. Evaluation and water testing. As part of the inspection and evaluation, water samples shall be collected and submitted by the local health sanitarian or a well contractor certified by the state to the state hygienic laboratory or other laboratory certified for drinking water analysis by the department of natural resources. The minimum yearly water analysis shall include coliform bacteria and nitrate (NO₃⁻) content. Total arsenic testing shall be performed once every three years. The water shall be deemed safe when there are no detectible coliform bacteria, when nitrate levels are less than 10 mg/L as nitrogen, and when total arsenic levels are 10 µg/L or less. A copy of the laboratory analysis report shall be provided to the department within 72 hours of receipt by the water supply.

c. Multiple wells supplying water. When the water supply obtains water from more than one well, each well connected to the water distribution system shall meet all of the requirements of these rules.

d. Deficiencies. When no apparent deficiencies exist with the well or its operations and the water supply is proven safe by meeting the minimum sampling and analysis requirements, water safety requirements have been met. Wells with deficiencies that result in unsafe water analysis require corrective actions through the use of a well contractor certified by the state.

e. When water is proven unsafe. When the water supply is proven unsafe by sampling and analysis, the facility shall immediately provide a known source of safe drinking water for all water users and hang notification at each point of water use disclosing the water is unsafe for drinking water uses. In addition, the facility shall provide a written statement to the department disclosing the unsafe result and detail a plan on how the water supply deficiencies will be corrected and the supply brought back into a safe and maintained condition. The statement shall be submitted to the department within ten days of the laboratory notice. All corrective work shall be performed and the water supply sampled and analyzed again within 45 days after any water test analysis report that indicates the water supply is unsafe for drinking water uses.

f. Water obtained from another source through hauling and storage must meet the requirements of the department of natural resources.

ITEM 5. Amend subrule 105.2(17) as follows:

105.2(17) Emergency evacuation and safety procedures. Upon admission, all children shall receive instruction regarding evacuation and safety procedures. All living units utilized by children shall have a posted plan for evacuation in case of and safety procedures regarding severe weather events, fire or disaster with practice other natural or man-made disasters. Practice fire drills shall be held at least every six months monthly, and severe weather drills shall be held twice annually.

ITEM 6. Amend subrule 105.3(2) as follows:

105.3(2) Health of employees. Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties tested for tuberculosis and have had a physical examination within six months prior to hiring, unless the staff can produce valid documentation of the physical and TB test from within the previous 3 years. A statement attesting to these facts shall be secured at the time of employment and filed in the personnel records of the staff person. A new statement shall be secured at least every three years. Physical examinations shall be completed at least every three years thereafter, or whenever circumstances require them more frequently. Evidence of these examinations or tests shall be included in each personnel file. The statement shall be signed examinations or tests shall be completed by one of the following:

a. to c. No change.

ITEM 7. Rescind and reserve rule 441—105.4(232).

ITEM 8. Amend rule 441—105.5(232) as follows:

441—105.5(232) Staff.

105.5(1) Number of staff.

a. *Generally.* A sufficient number of child care or house parent staff shall be on duty at all times so as to provide adequate coverage. The number of staff required will vary depending on the size and complexity of the program. All facilities shall have at least one staff person on duty. ~~Facilities having six or more residents shall have at least two staff persons on duty at all times that children are usually awake and present in the facility.~~ A minimum staff-to-child ratio of one child care worker to five children shall be maintained at all times children are awake and present in the facility and during supervised outings. ~~Coed facilities having more than five residents should have both male and female staff on duty at all times.~~ All child care or house parent staff shall be at least 18 years of age.

b. *On-call system.* ~~There shall be an on-call system for coed facilities to provide that staff of the same sex as the resident shall perform the following:~~ There shall be an on-call system to provide supervisory consultation. There shall be a written plan documenting this system.

~~(1) All personal body searches.~~

~~(2) Supervision of personal care.~~

c. *Prime programming time.* ~~A minimum staff-child ratio of one child care worker or house parent to five children shall be maintained during prime programming times.~~ Reserved.

d. *Night hours.* At night, there shall be a staff person awake in each living unit and making regular visual checks throughout the night. The visual checks shall be made at least every hour in shelter care and every half hour in detention. A log shall be kept of all checks, including the time of the check and any significant observations. The minimum staff-child ratio must be maintained at 1:16 during the overnight shift. ~~There shall be an on-call system which allows backup within minutes for both child care staff and casework personnel.~~

105.5(2) and 105.5(3) No change.

105.5(4) Organization and administration. Whenever there is a change in the name of the facility, the address of the facility, the executive, or the capacity, the information shall be reported to the ~~licensing manager department.~~ A table of organization including the identification of lines of responsibility and authority from policymaking to service to clients shall be available to the licensing staff. An executive director shall have full administrative responsibility for carrying out the policies, procedures and programs.

105.5(5) Record checks. Record checks are required for an entity being considered for a certificate of approval or a certificate of license or employment on a facility campus where children reside to determine whether any founded child abuse reports, convictions for crimes for the mistreatment or exploitation of children, or criminal convictions exist related to the person having been placed on a sex offender registry. The facility shall not employ or use any staff person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has been convicted of a crime involving the mistreatment or exploitation of a child. The facility shall not employ or use any staff person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has a record of a criminal conviction or founded child abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of a certificate of approval or a certificate of license, volunteering or employment. For each person working in a shelter care home on a facility campus where children reside, fingerprints shall be provided to the department of public safety for submission through the state criminal history repository to the United States Department of Justice, federal bureau of investigation, for a national criminal history check. Fingerprints shall be provided to the department of public safety for submission through the state criminal history repository to the United States

Department of Justice, federal bureau of investigation, for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required for any entity being considered for a certificate of approval or a certificate of license or employment by an approved entity on a facility campus where children reside.

a. and b. No change.

105.5(6) Record check procedure. Each entity being considered for a certificate of approval or a certificate of license or employment by an approved entity on a facility campus where children reside shall be checked for all of the following:

a. Records with the Iowa central abuse registry;

b. Records with the Iowa division of criminal investigation; c.

Records with the Iowa sex offender registry;

d. Records with the child abuse registry of any state where the person has lived during the past five years; and,

e. Fingerprints provided to the department of public safety for submission through the state criminal history repository to the United States Department of Justice, federal bureau of investigation, for a national criminal history check.

105.5(7) Evaluation of record. If the entity for whom background checks are required has a record of founded child or dependent adult abuse, a criminal conviction, or placement on a sex offender registry, the department shall complete an evaluation to determine that the abuse, criminal conviction, or placement on a sex offender registry does not warrant prohibition of a certificate of approval or a certificate of license or employment by an approved entity on a facility campus where children reside.

105.5(8) Evaluation form. The entity with the founded child or dependent adult abuse or criminal conviction report shall complete and return record check evaluation forms required by the department within ten calendar days of the date of receipt to be used to assist in the evaluation.

105.5(9) Evaluation decision. The department shall conduct the evaluation and issue a notice of decision in writing to the requesting entity.

ITEM 9. Amend paragraph 105.6(2)“c” as follows:

c. When the child is in the facility more than four days, the following information shall be ~~made available to requested by~~ the facility if not yet received.

(1) to (3) No change.

ITEM 10. Amend subrule 105.8(1) as follows:

105.8(1) Care Service plan. There shall be a written care-service plan developed for each resident remaining in the facility over four days and completed according to the time frames identified for the contracted service. The care-service plan will be based on individual needs determined through the assessment of each youth. The care-service plan shall be developed in consultation with child care services, probation services, social services and educational, medical, psychiatric and psychological personnel as appropriate. The plan shall include:

a. to e. No change.

ITEM 11. Amend paragraph 105.8(5)“b” as follows:

b. ~~The facility Shelter care homes~~ shall plan and carry out efforts to establish and maintain workable relationships with the community recreational resources. The facility staff shall enlist the support of these resources to provide opportunities for children to participate in community recreational activities.

ITEM 12. Amend subrule 105.8(8) as follows:

105.8(8) Dietary program. The facility shall provide properly planned, nutritious and inviting food and take into consideration the special food-dietary and health needs and tastes of children. The facility shall follow all dietary recommendations prescribed by medical personnel or a dietitian licensed in the state of Iowa.

ITEM 13. Adopt the following new subrule 105.8(10):

105.8(10) Safety, protection, and well-being of children in care. Facilities shall develop and follow written policies that

that assure the safety, protection, and well-being of children in care. Policies shall address, but not be limited to, the following:

- a. Supportive leadership of the facility that promotes protecting each child from abuse or bullying from other children and staff.
- b. Defining the facility's culture to reduce the use of unnecessary restraint.
- c. Clear definitions of unsafe behavior and the emergency situations when it is appropriate to use physical interventions.
- d. Staff training and development that give staff confidence that they are supported by leadership with proper supervision and ongoing access to information about best practices and evidence-based approaches to care.
- e. Adequate supervision of children while the children are using any hazardous or dangerous objects or equipment and when children are using the Internet or other social media.
- f. The social, cultural, and developmental needs of children in care.

ITEM 14. Adopt the following **new** subrule 105.8(11):

105.8(11) Staff duties. The staff duties shall include, but not be limited to, the following:

- a. Providing a supportive atmosphere for each child.
- b. Providing for coordination of internal and external activities of each child as needed.
- c. Providing leadership and guidance to each child as needed.
- d. Being responsible for overseeing and maintaining the general health and well-being of each child.
- e. Supervising all living activities.
- f. At all times, knowing where the children are and where they are supposed to be to assure ongoing safety.
- g. Providing for a liaison with the referring agency.
- h. Monitoring and recording behavior on a daily basis.

ITEM 15. Adopt the following **new** subrule 105.8(12):

105.8(12) Volunteers. A facility that utilizes volunteers to work directly with a particular child or group of children shall have a written plan for using volunteers. This plan shall be given to all volunteers. The plan shall indicate that all volunteers shall:

- a. Be directly supervised by a paid staff member.
- b. Be oriented and trained in the philosophy of the facility and the needs of children in care and methods of meeting those needs.
- c. Be subject to character, reference, and record check requirements as described in this chapter.

ITEM 16. Amend rule 441—105.9(232) as follows:**441—105.9(232) Medication management and administration.** The facility shall have and follow written policies and procedures governing the methods of handling prescription drugs and over-the-counter drugs within the facility. No prescription or narcotic drugs are allowed in the facility without the authorization of a licensed physician or other prescriber authorized by law. Only drugs which have been approved by the federal Food and Drug Administration for use in the United States may be used. No experimental drugs may be used.

105.9(1) Obtaining prescription medications. Facilities shall permit prescription medications to be brought into the facility for a child.

- a. Prescription medication in its original container, clearly labeled and prescribed for the child, may be accepted as legitimate prescription medication for the child. The label serves as verification that the medication was ordered by an authorized prescriber. Medication shall be prescribed by a provider authorized to prescribe the medication. Medication provided to residents shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Iowa Code, from a licensed pharmacy in another state according to the laws of that state, or by a licensed physician.

b. No change.

105.9(2) No change.

105.9(3) Storing medications. Prescription and nonprescription medications shall be stored in a locked cabinet, a locked refrigerator, or a locked box within an unlocked refrigerator.

a. ~~Controlled substances-Schedule II medications~~ shall be stored in a locked box within a locked cabinet. Nothing other than ~~controlled substances-Schedule II medications~~ shall be stored in the locked box. ~~Controlled substances-Schedule II medications~~ requiring refrigeration also shall be maintained within a double-locked container separate from food and other items.

b. The facility administrator shall determine distribution and maintenance of keys or other access to the medication storage cabinets and boxes.

c. A shelter facility administrator or the administrator's designee may preapprove shelter staff to carry prescription or nonprescription medications with them temporarily for use ~~while on day trips or at sites away from the facility.~~

105.9(4) Labeling medications. ~~Controlled substances-Schedule II medications~~ and prescription medications shall be maintained in their original containers, clearly labeled by an authorized prescriber and prescribed for the child. Sample prescription medications shall be accompanied by a written prescription. Nonprescription medications shall be maintained as purchased in their original containers.

105.9(5) Administering ~~controlled-Schedule II medications.~~ Only staff who have completed a medication administration management course shall be allowed to administer ~~controlled substances-Schedule II medications.~~

105.9(6) Administering prescription and nonprescription medications. The facility administrator shall determine and provide written authority as to which staff may administer prescription and nonprescription medications.

a. Prescription medications shall be administered only in accordance with the orders of the authorized prescriber. Nonprescription medications shall be administered by following the directions on the label.

b. The facility administrator or the administrator's designee may allow a child to self-administer prescription ~~and nonprescription medication in appropriate situations with written authorization by the authorized prescriber.~~ The facility shall have written policies relating to self-administration of prescription and nonprescription medication. The facility shall require documentation if the child self-administers a medication.

105.9(7) No change.

105.9(8) Medication for discharged residents. When a child is discharged or leaves the facility, the facility shall turn over to a responsible agent ~~controlled substances-Schedule II medications~~ and prescription medications currently being administered. The facility may send nonprescription medications with the child as needed. The facility shall document in the child's file:

a. to c. No change.

105.9(9) Destroying outdated and unused medications. Unused ~~controlled-Schedule II medications~~ and prescription medications ~~kept at the facility for more than six months may not be kept at the facility for more than 15 days~~ after the child has left the facility and the Schedule II medications and prescription medications shall be destroyed by the administrator or the administrator's designee in the presence of at least one witness. Outdated, discontinued, or unusable nonprescription medications shall also be destroyed in a similar manner. The person destroying the medication shall document:

a. to d. No change.

ITEM 17. Amend paragraph **105.10(3)"f"** as follows:

f. A staff member shall always be ~~within hearing distance-positioned outside of the control room and the child shall be visually checked by the staff at least every 15 minutes and each check shall be recorded.~~ Visual and auditory observations of the child's behavior and condition shall be recorded at five-minute intervals, and a complete written report shall be documented in the child's file by the end of the staff person's work shift.

ITEM 18. Amend rule 441—105.14(232) as follows:

441—105.14(232) Daily log. The facility shall maintain a daily log to generally record noteworthy occurrences regarding the children in care. The log shall be used to note general progress in regard to the care plan and any problem areas or unusual behavior for each child. Problem areas or unusual behavior for specific children shall be recorded in individual children's records.

ITEM 19.1. Amend subrule 105.16(1) as follows:

105.16(1) Generally. A facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Discipline shall not include withholding of basic necessities such as food, clothing, or sleep. Discipline shall not be used for anyone other than a child whose actions resulted in consequences. Group discipline shall not be used because of actions of an individual child or other children. Agency staff shall be in control of and responsible for discipline at all times.

ITEM 19.2 Amend subrule 441-105.16(3) to add paragraph as follows:

105.16(3)e. A child known to be pregnant may not be restrained during labor, delivery, and post-partum recovery, unless credible, reasonable grounds exist to believe the detainee presents an immediate and serious threat of hurting herself, staff, or others.

ITEM 19.3 Amend subrule 441-105.16(3) to add paragraph as follows:

105.16(3)f. A facility may not use abdominal restraints, leg and ankle restraints, wrist restraints behind the back, and four-point restraints on a known pregnant child, unless credible reasonable ground exist to believe the detainee presents an immediate and serious threat of hurting herself, staff, or others; or reasonable grounds exist to believe the detainee presents an immediate and credible risk of escape that cannot be reasonably minimized through any other method.

ITEM 20. Amend subrule 105.16(4) as follows:

105.16(4) Room confinement—juvenile detention home only. ~~Facilities shall provide sufficient programming and staff coverage to enable children to be involved in group activities during the day and evening hours. A child shall only be confined to the child's room for illness, at the child's own request, or for disciplinary reasons. A juvenile detention home may confine a child to the child's room during normal sleeping hours or for disciplinary reasons if the facility has written policies and procedures which are approved by the department regarding this confinement that include, but are not limited to, the reasons for and time limitations of the confinement.~~

ITEM 21. Renumber subrule **105.16(5)** as **105.16(6)**.

ITEM 22. Adopt the following **new** subrule 105.16(5):

105.16(5) Time out—juvenile shelter care home only.

- a. A resident in time out must never be physically prevented from leaving the time out area.
- b. Time out may take place away from the area of activity or from other residents, such as in the resident's room, or in the area of activity of other residents.
- c. Staff must monitor the resident while the resident is in time out.

ITEM 23. Rescind paragraph 105.17(4)“b” and adopt the following new paragraph in lieu thereof:

b. A summary related to discharge from the facility including:

- (1) The name, address, and relationship of the person or agency to whom the child was discharged.
- (2) The discharge summary (as included in the service plan).
- (3) Final disposition of a child’s medications as applicable.
- (4) Identification of who transported the child and destination post discharge.

ITEM 24. Rescind rule 441—105.18(232) and adopt the following new rule in lieu thereof:441—105.18(232) Discharge. Children in shelter care should be discharged to, preferably, a permanent placement, or, alternatively, a lower level of care in a family-like setting, at the earliest possible time, preferably within 14 days. The facility shall collaborate with referral workers to assess each child’s need for ongoing placement and the reasons for longer stays shall be documented in the child’s case file. Children in detention shall be discharged as determined by the court.

ITEM 25. Amend rule 441—105.19(232), introductory paragraph, as follows:441—105.19(232) Approval. The department will issue a Certificate of Approval ~~Form 470-0620,~~ or a certificate of license annually without cost to any juvenile detention home or juvenile shelter care home which meets the standards. The department may offer consultation to assist homes in meeting the standards.

ITEM 26. Amend subrule 105.19(7) as follows:

105.19(7) Certificate of approval or certificate of license. Upon approval, ~~the home county or multicounty homes~~ will be issued a certificate of approval and private juvenile detention and shelter care homes will be issued a certificate of license containing the name of the home, address, capacity, and the date of expiration. Renewals will be shown by a seal bearing the new date of expiration, unless a change requires a new certificate to be issued.

ITEM 27. Rescind rule 441—105.20(232) and adopt the following new rule in lieu thereof:441—105.20(232) Provisional approval.

105.20(1) Required conditions. The administrator may issue a provisional license for not more than one year when a facility does not meet the requirements of this chapter and the facility submits a written corrective action plan that is approved by the administrator to bring the facility into compliance with the applicable requirements.

105.20(2) Written report. The department or the department’s designee will provide a report identifying the reasons for the provisional license and the standards that have not been met.

105.20(3) Corrective action. The director of the facility, chairperson of the county board of supervisors, or chairperson of the multicounty board of directors shall provide the department with a written plan of action that is approved by the department for correcting the deficiencies to bring the facility into compliance with the applicable requirements. The plan shall give specific dates by which the corrective action will be completed.

105.20(4) Completed corrective action. When the corrective action is completed on or before the date specified, a full approval shall be issued.

105.20(5) Uncompleted corrective action. When the corrective action is not completed by the date specified on a provisional approval, the department shall not grant a full approval and has the option of rejecting or extending the provisional approval. An extension of a provisional approval shall not cause the effective period of a provisional approval to exceed 18 months. If the corrective action plan is not completed within 18 months, the approval shall be rejected.

ITEM 28. Amend paragraph 105.21(1)“d” as follows:

d. ~~Each~~ Except for mechanical restraint of a child by the staff of a juvenile detention facility for the amount of time needed while that child is being transported to a point outside the facility and as necessary when there is a serious risk of the child exiting a vehicle while the vehicle is in motion or otherwise absconding, each authorization of mechanical restraint shall not exceed ~~one~~ 1 hour in duration without a visit by and written authorization from a licensed psychologist, psychiatrist or physician ~~or psychologist employed by a local mental health center.~~

ITEM 29. Amend paragraph 105.21(1)“e” as follows:

e. No child shall be kept in mechanical restraint for more than 1 hour in a 12-hour period without a visit by and written authorization from a licensed psychologist, psychiatrist or physician ~~or psychologist employed by a local mental health center.~~

ITEM 30. Amend paragraph 105.21(2)“c” as follows:

c. Each facility authorized to use mechanical restraint shall submit a quarterly report which shall include all the information required in paragraph 105.21(2)“b,” ~~to the bureau of adult, children and family services of the department which shall include all the information required in 105.21(2)“b.”~~ its licensing manager.

ITEM 31. Amend subrule 105.21(4) as follows:

105.21(4) *In transporting children.* ~~Notwithstanding 105.21(1)“d,” mechanical restraint of a child by the staff of a juvenile detention facility while that child is being transported to a point outside the facility is permitted when there is a serious risk of the child exiting the vehicle while the vehicle is in motion. The facility shall place a written report on each use in the child’s case record and the mechanical restraint file. This report shall document the necessity for the use of restraint.~~

Seat belts are not considered mechanical restraints. Agency policies should encourage the use of seat belts and comply with Iowa law while transporting children.

ITEM 32. Adopt the following new rule 441—105.23(232):**441—105.23(232) Mandatory reporting of child abuse and training.**

105.23(1) *Mandatory reporters.* All defined in Iowa Code section 232.69 who, in the scope of professional practice or in their employment responsibilities, examine, attend, counsel, or treat a child and reasonably believe a child has suffered abuse, shall make a report in accordance with Iowa Code section 232.69 whenever the provider reasonably believes a child for whom the provider is providing foster care has suffered abuse.

105.23(2) *Required training.* Mandatory reporters shall receive training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

105.23(3) *Training documentation.* Each licensee shall develop and maintain a written record for each mandatory reporter in order to document the content and amount of training.

This rule is intended to implement Iowa Code section 232.69.

ITEM 33. Amend rule 441—112.1(237) as follows:**441—112.1(237) Applicability.** This chapter relates to licensing procedures for all child foster care facilities authorized by Iowa Code chapter 237. Rules relating to specific types of facilities are located in 441—Chapter 113, “Licensing and Regulation of Foster Family Homes,” 441—Chapter 114, “Licensing and Regulation of All Group Living Foster Care Facilities for Children,” 441—Chapter 115, “Licensing and Regulation of Comprehensive Residential Facilities for Children,” and 441—Chapter 116, “Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability or Brain Injury.”

This rule is intended to implement Iowa Code chapter 237.

ITEM 34. Adopt the following new definition of “Administrator” in rule **441—112.2(237)**:

“*Administrator,*” when used for matters related to licensing, means the administrator of the division of adult, children and family services.

ITEM 35. Amend rule **441—112.2(237)**, definitions of “Applicant,” “Comprehensive residential facility,” “Director’s designee,” and “Residential facility for children with an intellectual disability” as follows:

“*Applicant:*”

1. No change.
2. For a proprietary ~~child-care~~ facility, the applicant is the owner or designee of the facility.
3. No change.

“*Comprehensive residential facility*” means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual ~~treatment-service~~ plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, and mechanical restraints, ~~and chemical restraints~~ when these controls meet licensing requirements.

"Director's-Administrator's designee:"

1. For group facilities, the ~~director's-administrator's~~ designee is the chief of the bureau of ~~protective-child welfare and community services~~.

2. For foster family homes, the designee is the department of human services' service area manager.

"Residential facility for children with an intellectual disability or brain injury" means any residential facility which serves children with an intellectual disability as defined in Iowa Code chapter 222 or children with brain injury as defined in Iowa Code chapter 225C.

ITEM 36. Amend paragraph **112.3(1)"b"** as follows:

b. Group care. A person wishing to apply for a group care license shall ~~may~~ contact the department:

(1) ~~Through the "Child Welfare" link~~ Using the "Contact Us" link found on the department's Web-Internet site , - www.dhs.iowa.gov at dhs.iowa.gov; or

(2) By mail to the ~~DHS-Iowa Department of Human Services, Division of Child-Adult, Children and Family Services, Attn: Group Care Licensing, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.~~

ITEM 37. Amend subrule 112.4(6) as follows:

112.4(6) A foster family home license shall be approved for a term of one year for the first and second years of licensure. Thereafter, the license shall be approved for a term of two years unless it is determined by the administrator that a one-year license shall be issued. A group facility license shall be approved for a term of one to three years according to the following criteria:

a. A one-year license may be approved for all new ~~agencies-facilities~~ that meet licensure standards.

b. ~~A two-year-one- to two-year~~ license may be approved ~~upon completion of a survey for a renewal license when it is determined:~~

(1) Some health or safety concerns have been identified ~~, but they are determined to be minor or easily corrected; or~~ or

(2) Some complaints against a facility have been substantiated ~~, but they are determined to be minor; and or~~

(3) Deficiencies ~~that have been identified are determined to be minor or easily corrected.~~

c. A three-year license may be approved ~~upon completion of a survey for a renewal license when:~~

(1) to (3) No change.

ITEM 38. Amend paragraph **112.5(1)"a"** as follows:

a. The minimum standards set forth in these rules are not met and a provisional license is inappropriate or disapproved by ~~the director's-administrator or administrator's designee.~~

ITEM 39. Amend subrule 112.7(1) as follows:

112.7(1) ~~Statement of reasons-Time frame for provisional licenses.~~ Provisional licenses shall be accompanied by a statement of the reasons for the provisional license, the standards that have not been met, the date that the facility must make required changes to meet standards. The administrator may issue a provisional license for not more than one year when a licensee's facility does not meet the requirements of this chapter and the licensee submits a written corrective action plan that is approved by the administrator to bring the facility into compliance with the applicable requirements.

ITEM 40. Amend subrule 112.7(2) as follows:

112.7(2) ~~Corrective action-Written report.~~ The facility shall furnish the licensing agency with a plan of action to correct deficiencies listed that resulted in the provisional license. The plan shall give specific dates upon which the corrective action will be completed. The administrator or the administrator's designee will provide a report identifying the reasons for the provisional license and the standards that have not been met.

ITEM 41. Adopt the following new subrule 112.7(3):

112.7(3) Corrective action plan. The facility shall furnish the licensing agency with a plan of action to correct deficiencies listed that resulted in the provisional license. The plan shall give specific dates upon which the corrective action will be completed.

ITEM 42. Amend subrule 112.9(2) as follows:

112.9(2) Requirements for emergency suspension. The emergency suspension of a license by the ~~director~~ administrator or administrator's designee shall occur only when all of the following conditions exist:

a. to d. No change.

ITEM 43. Amend subrule 112.9(3) as follows:

112.9(3) Requirements for time-limited suspensions. The time-limited suspension of a license by the ~~director~~ administrator or administrator's designee shall occur only when all of the following conditions exist:

a. to f. No change.

ITEM 44. Amend rule 441—112.10(232) as follows:**441—112.10(232) Mandatory reporting of child abuse and training.**

112.10(1) Mandatory reporters. ~~The following foster care providers All defined in Iowa Code section 232.69 who, in the scope of professional practice or in their employment responsibilities, examine, attend, counsel, or treat a child and reasonably believe a child has suffered abuse, shall make a report, in accordance with Iowa Code section 232.69, whenever they the provider reasonably believe believes a child for whom they are the provider is providing foster care has suffered abuse:—~~

a. ~~Any social worker who is employed by a licensed child foster care facility and who works with foster children.~~

b. ~~Any licensed foster parent providing child foster care.~~

112.10(2) Required training. ~~After completing the initial mandatory reporter training, and every five years thereafter, any person required to make a report under subrule 112.10(1) shall complete two hours of training relating to the identification and reporting of child abuse. Mandatory reporters shall receive training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.~~

~~**112.10(3) Training provider.**~~

~~a. If the foster care provider is a social worker employed by a licensed child foster care facility, the employer shall be responsible for providing the required training in child abuse identification and reporting.~~

~~b. If the foster care provider is a licensed foster parent, the foster parent shall be responsible for obtaining the required two-hour training in child abuse identification and reporting as part of a continuing education program required under Iowa Code section 232.69 and chapter 272C and approved by the department of public health.~~

~~**112.10(4) Training content.**~~

~~a. Training in child abuse identification shall include physical and behavioral signs of physical abuse, denial of critical care, sexual abuse and other categories of child abuse pursuant to Iowa Code section 232.68.~~

~~b. Training in child abuse reporting shall include reporting requirements and procedures.~~

~~**112.10(5) 112.10(3) Training documentation.** Each licensee shall develop and maintain a written record for each mandatory reporter in order to document the content and amount of training.~~

~~a. If the foster care provider is a social worker employed by a licensed child foster care facility, the employer shall document in the employee's personnel record the content and amount of training.~~

~~b. If the foster care provider is a licensed foster parent, the foster parent shall be responsible for securing documentation of the training content, amount, and provider, and shall forward the documentation to the department's recruitment and retention contractor, which will provide a copy to the department licensing worker for the service area where the family resides for inclusion in the licensing file.~~

This rule is intended to implement Iowa Code section 232.69.

ITEM 45. Adopt the following new rule 441—112.12:441—112.12(237) **Record checks**. Record checks as defined in 441—Chapter 114 are required for any entity being considered for licensure or employment by a licensee on a facility campus where children reside to determine whether any applicant has any founded child abuse reports or criminal convictions or has been placed on a sex offender registry.

ITEM 46. Adopt the following new definitions of “Immediate family,” “Schedule II medications” and “Time out” in rule 441—114.2(237):

“*Immediate family*,” for the purposes of this chapter, means persons who have a blood or legal relationship with the child.

“*Schedule II medications*” means those controlled substances identified in Iowa Code chapter 124.

“*Time out*” means the temporary and short-term restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control. Staff physically preventing the resident from leaving the time out area would be considered seclusion in control room conditions.

ITEM 47. Amend rule 441—114.2(237), definition of “Staff,” as follows:

“*Staff*” means any person providing care or services to or on behalf of the ~~facility residents~~ whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

ITEM 48. Rescind the definitions of “Highly structured juvenile program,” “Locked cottage,” and “Prime programming time” in rule 441—114.2(237).

ITEM 49. Amend subrule 114.4(1) as follows:

114.4(1) Bathroom facilities.

a. No change.

b. Each bathroom shall be properly equipped with toilet tissue in dispensers, paper towels, or functional hand dryers, soap, and other items required for personal hygiene ~~unless children are individually given these items. Paper towels, when used, and toilet tissue shall be in dispensers.~~

c. to e. No change.

f. At least one toilet and one lavatory wash basin shall be provided for each six children or portion thereof.

g. to k. No change.

ITEM 50. Rescind subrule 114.4(8) and adopt the following new subrule in lieu thereof:

114.4(8) Private water supplies. Any facility that serves at least 25 people for at least 60 days during the year and is supplied by its own well meets the definition of a public water supply and must be regulated by the department of natural resources.

a. Maintenance and operation. Each privately operated water supply shall be maintained and operated in a manner that ensures safe drinking water. Each water supply used as part of a facility shall be annually inspected and evaluated for deficiencies that may allow contaminants access to the well interior. Items such as open or loose well caps, missing or defective well vents, poor drainage around the wells, and the nearby storage of potential contaminants shall be evaluated. All deficiencies shall be corrected within 30 days of discovery by a well contractor certified by the state.

b. Evaluation and water testing. As part of the inspection and evaluation, water samples shall be collected and submitted by the local health sanitarian or a well contractor certified by the state to the state hygienic laboratory or other laboratory certified for drinking water analysis by the department of natural resources. The minimum yearly water analysis shall include coliform bacteria and nitrate (NO₃-) content. Total arsenic testing shall be performed once every three years. The water shall be deemed safe when there are no detectible coliform bacteria, when nitrate levels are less than 10 mg/L as nitrogen, and when total arsenic levels are 10 µg/L or less. A copy of the laboratory analysis report shall be provided to the department within 72 hours of receipt by the water supply.

c. Multiple wells supplying water. When the water supply obtains water from more than one well, each well connected to the water distribution system shall meet all of the requirements of these rules.

d. Deficiencies. When no apparent deficiencies exist with the well or its operations and the water supply is proven safe by meeting the minimum sampling and analysis requirements, water safety requirements have been met. Wells with deficiencies that result in unsafe water analysis require corrective actions through the use of a well contractor certified by the state.

e. When water is proven unsafe. When the water supply is proven unsafe by sampling and analysis, the facility shall immediately provide a known source of safe drinking water for all water users and hang notification at each point of water use disclosing the water is unsafe for drinking water uses. In addition, the facility shall provide a written statement to the department disclosing the unsafe result and detail a plan on how the water supply deficiencies will be corrected and the supply brought back into a safe and maintained condition. The statement shall be submitted to the department within ten days of the laboratory notice. All corrective work shall be performed and the water supply sampled and analyzed again within 45 days from any water test analysis report that indicates the water supply is unsafe for drinking water uses.

f. Water obtained from another source through hauling and storage must meet the requirements of the department of natural resources.

ITEM 51. Amend subrule 114.5(1) as follows:

114.5(1) General. ~~a.~~ Facilities shall take sufficient measures to ensure the safety of the children in care in all of its programs.

~~b.~~ Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

~~c.~~ Radiators, registers, and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

~~d.~~ Fuse boxes shall be inaccessible to children.

~~e.~~ Facilities shall have written procedures for the handling and storage of hazardous materials.

~~f.~~ Firearms and ammunition shall be kept under lock and key and inaccessible to children. When firearms are used, the facility shall have written policies regarding their purpose, use, and storage.

~~g.~~ All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

~~h.~~ The facility shall have policies regarding fishing ponds, lakes, or any bodies of water located on or near the institution grounds and accessible to the children.

ITEM 52. Renumber subrules **114.5(2)** to **114.5(4)** as **114.5(3)** to **114.5(5)**.

ITEM 53. Adopt the following new subrule 114.5(2):

114.5(2) Premises.

a. Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

b. Radiators, registers, and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

c. Fuse boxes and circuit breakers shall be inaccessible to children.

d. Facilities shall have written procedures for the handling and storage of hazardous materials.

e. Firearms and ammunition shall be kept under lock and key and inaccessible to children. When firearms are used, the facility shall have written policies regarding their purpose, use, and storage.

f. All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

g. The facility shall have policies regarding fishing ponds, lakes, or any bodies of water located on or near the facility grounds and accessible to the children.

ITEM 54. Amend renumbered subrule 114.5(3) as follows:

114.5(3) Emergency evacuation and safety procedures. Upon admission all children shall receive instruction regarding evacuation and safety procedures. All living units utilized by children shall have a posted plan for evacuation in case of and safety procedures regarding severe weather events, fire or disaster with practice other natural or man-made disasters. Practice fire drills shall be held at least every six months monthly and severe weather drills shall be held twice annually.

ITEM 55. Adopt the following new subrule 114.5(6):

114.5(6) Safety, protection, and well-being of children in care. Facilities shall develop and follow written policies and procedures that assure the safety, protection, and well-being of children in care. Policies shall address, but not be limited to, the following:

- a. Supportive leadership of the facility that promotes protecting each child from abuse or bullying from other children and staff.
- b. Defining the facility's culture to reduce the use of unnecessary restraint.
- c. Clear definitions of unsafe behavior and the emergency situations when it is appropriate to use physical interventions.
- d. Staff training and development that give staff confidence they are supported by leadership with proper supervision and ongoing access to information about best practices and evidence-based approaches to care.
- e. Adequate supervision of children while the children are using any hazardous or dangerous objects or equipment and when children are using the Internet or other social media.
- f. The social, cultural, and developmental needs of children in care.

This rule is intended to implement Iowa Code section 237.3.

ITEM 56. Amend rule 441—114.6(237) as follows:**441—114.6(237) Organization and administration.** Any change in the name of the facility, the address of the facility, the executive, or the capacity shall be reported to the licensing manager department.

114.6(1) No change.

114.6(2) Purpose of agency or facility. The purpose or function of the organization shall be clearly defined in writing and shall include a description of the children to be accepted for care and the services offered.

114.6(3) No change.

114.6(4) Executive director. The governing body or proprietor or partner(s) shall select and appoint an executive director with full administrative responsibility and qualifications for carrying out the policies, procedures and programs established by the governing body.

114.6(5) No change.

This rule is intended to implement Iowa Code section 237.2.

ITEM 57. Amend subrule 114.7(2) as follows:

114.7(2) Health of staff. Each staff person who has direct client contact or is involved in food preparation shall be medically determined to ~~be free of serious infectious communicable diseases and able to perform assigned duties~~ be tested for tuberculosis and have a physical examination within six months prior to hiring. Physical examinations shall be completed every three years thereafter, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous 3 years. A statement attesting to these facts shall be secured at the time of employment and filed in the staff record of the staff person. A new statement shall be secured at least every three years. Evidence of these examinations or tests shall be included in each personnel file. The statement shall be signed ~~examinations or tests shall be completed by one of the following:~~

- a. to c. No change.

ITEM 58. Amend paragraph **114.7(3)“a”** as follows:

a. The facility shall maintain the following information with respect to each staff person:

(1) and (2) No change.

(3) ~~Documentation that a criminal records check with the Iowa division of criminal investigation has been completed on the staff person prior to providing any care or service directly or indirectly to children under the care of the agency. A copy of the department's evaluation of the criminal record check shall be kept in the staff record of all record checks and evaluations as required in subrule 114.24(1).~~

(4) No change.

(5) ~~Documentation that a check of the staff person has been completed with the Iowa central abuse registry for any founded reports of child abuse prior to the person's providing any care or services directly or indirectly to children under the care of the agency. A copy of the department's evaluation of this child abuse record check shall be kept in the staff record~~ Reserved.

(6) Records of a ~~health-physical~~ examination or a record of a health report, as required in subrule 114.7(2), plus a written record of subsequent health services rendered to staff necessary to ensure that each individual is physically able to perform the job duties or functions.

(7) ~~If the staff person has completed and submitted Form 470-2310, Record Check Evaluation, to the agency, a copy shall be kept in the staff record Reserved.~~

(8) and (9) No change.

ITEM 59. Amend paragraph **114.8(2)“d”** as follows:

d. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff to client ratio during ~~prime programming time~~ all times children are awake and present in the facility and during supervised outings.

ITEM 60. Amend subrule 114.8(3) as follows:

114.8(3) Staff duties.

a. No change.

b. Caseworkers shall:

(1) Develop a ~~care-service~~ plan for each child containing goals and objectives with projected dates of accomplishment and shall involve the client, referral agency, and family whenever possible.

(2) No change.

c. The facility staff shall ~~define in writing who shall~~ be responsible for the following staff duties:

(1) Documenting case reassessments quarterly, involving the same personnel as previously involved in ~~care-service~~ plan development.

(2) Documenting the implementation of the ~~care-service~~ plan.

(3) to (11) No change.

(12) At all times, knowing where the children are and where they are supposed to be to assure ongoing safety.

ITEM 61. Amend subparagraph **114.8(4)“c”(5)** as follows:

(5) Access to current literature, ~~including books, monographs, and journals~~ information and evidence based practices relevant to the facility's services.

ITEM 62. Adopt the following new subrule 114.8(5):

114.8(5) Volunteers. A facility that utilizes volunteers to work directly with a particular child or group of children shall have a written plan for using volunteers. This plan shall be given to all volunteers. The plan shall indicate that all volunteers shall:

a. Be directly supervised by a paid staff member.

b. Be oriented and trained in the philosophy of the facility and the needs of children in care, and methods of meeting those needs.

c. Be subject to character, reference, and record check requirements described in ~~Iowa Administrative Code 441—Chapter 112 and in this subrule 114.24(1).~~

ITEM 63. Amend subrule 114.9(3) as follows:

114.9(3) Referral requirements-information. The following information shall be made available prior to any decision being made regarding the acceptance of a child. The following information shall be available prior to any decision being made regarding the acceptance of a child—requested by the facility if not yet received.:

a. to *g.* No change.

ITEM 64. Amend subrule 114.9(5) as follows:

114.9(5) Personal assessment. At the time of intake, individual needs will be identified by staff based on written and verbal information from referral sources, observable behavior at intake and the initial interview with youth or family, school contacts, physical examinations, and other relevant material. The individual assessment shall provide the basis for development of a care service plan for each child.

ITEM 65. Amend subrule 114.10(2) as follows:

114.10(2) *Care-Service plan.* There shall be a written ~~care-service~~ plan for each child. The ~~care-service~~ plan shall be based on the individual needs determined through the assessment of each resident, provide for consultation with the family, and shall include the following:

- a. No change.
- b. Description of planned services including measurable goals and objectives which indicate which staff person will be responsible for the specific services in the plan.
- c. No change.
- d. A discharge summary.

ITEM 66. Rescind subrule 114.10(4) and adopt the following **new** subrule in lieu thereof:

114.10(4) *Daily log.* The facility shall maintain a daily log to generally record noteworthy occurrences regarding the children in care. Problem areas or unusual behavior for specific children shall be recorded in individual children's records.

ITEM 67. Amend paragraph **114.10(6)"d"** as follows:

- d. A facility shall have and staff shall follow written procedures ~~for staff members to follow~~ in case of medical emergency.

ITEM 68. Amend subrule 114.10(7) as follows:

114.10(7) *Dietary program.* The facility shall provide properly planned, nutritious and inviting food and take into consideration the ~~special food dietary and health needs and tastes of children.~~ The facility shall follow all dietary recommendations prescribed by medical personnel or a dietitian licensed in the state of Iowa.

ITEM 69. Rescind subrule 114.10(8) and adopt the following **new** subrule in lieu thereof:

114.10(8) *Recreation and leisure programs.*

- a. The facility shall provide adequately designed and maintained indoor and outdoor activity areas, equipment, and equipment storage facilities appropriate for the residents it serves. There shall be a variety of activity areas and equipment so that all children can be active participants in different types of individual and group sports and other motor activities.
- b. Games, toys, equipment, and arts and crafts material shall be selected according to the ages and number of children with consideration to the needs of the children to engage in active and quiet play.
- c. The facility shall plan and carry out efforts to establish and maintain workable relationships with community recreational resources so these resources may provide opportunities for children to participate in community recreational activities.

ITEM 70. Amend subrule 114.10(9) as follows:

114.10(9) *Casework services.* A facility shall provide or obtain casework services in the form of counseling in accordance with the needs of each child's individual ~~care-service~~ plan. Casework services include crisis intervention, daily living skills, interpersonal relationships, future planning and preparation for placement as required by the child.

ITEM 71. Rescind and reserve subrule **114.10(11)**.

ITEM 72. Amend paragraph **114.11(2)"g"** as follows:

- g. Telephone number and address of the agency or court making the referral and contact information of the child's attorney or guardian ad litem.

ITEM 73. Amend subrule 114.11(9) as follows:

114.11(9) *Care-Service plan.* Individual child ~~care-service~~ plan, ~~and semiannual review quarterly update, and revision-revisions of care-the service plan.~~ The service plan shall be updated quarterly or any time upon receipt of a new case permanency plan or juvenile court services plan or as otherwise needed to address the changing needs of the child. Discharge summary completing the service plan information shall be completed upon a child's discharge from placement.

ITEM 74. Amend subrule 114.11(10) as follows:

114.11(10) ~~Dietation-Documentation.~~ The following information shall be documented in each child's record.

a. No change.

b. ~~Information on release of the child from the facility including the name, address and relationship of the person or agency to whom the child was released.~~ A summary related to discharge including:

(1) The name, address and relationship of the person or agency to whom the child was released.

(2) The discharge summary (as included in the service plan).

(3) Final disposition of a child's medications as applicable.

(4) Identification of who transported the child and destination post discharge.

ITEM 75. Adopt the following **new** subrule 114.11(11):

114.11(11) *Electronic records.* An authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the residents, who are served as a result of a contract with DHS, of the facility.

a. If access to an electronic record is requested by the authorized representative of the department, the facility may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion.

b. The facility shall provide a terminal where the authorized representative may access records.

c. If the facility is unable to provide direct print capability to the authorized representative, the facility shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation.

ITEM 76. Amend rule 441—114.12(237), introductory paragraph, as follows:**441—114.12(237) Drug utilization and control.** The agency shall have and follow written policies and procedures governing the methods of handling prescription drugs and over-the-counter drugs within the facility. No prescription or narcotic drugs are to be allowed in the facility without the authorization of a licensed physician or authorized prescriber.

ITEM 77. Amend subrule 114.12(2) as follows:

114.12(2) *Prescribed by physician or other authorized prescriber.* Drugs shall be prescribed by a physician licensed to practice in the state of Iowa or the state in which the physician is currently practicing, or by an advanced registered nurse practitioner or physician assistant as permitted by Iowa law, and may be prescribed only for use in accordance with dosage ranges and indications approved by the federal Food and Drug Administration.

ITEM 78. Amend subrule 114.12(4) as follows:

114.12(4) *Locked cabinet.* All drugs shall be maintained in a locked cabinet. ~~Controlled substances-Schedule II medications~~ shall be maintained in a locked box within the locked cabinet. The cabinet key shall be in the possession of a staff person. A bathroom shall not be used for drug storage. A documented exception can be made by a physician for persons identified in these rules who may allow self-administered drugs as discussed in subrule 114.12(17).

ITEM 79. Amend subrule 114.12(9) as follows:

114.12(9) *Medication for discharged residents.* When a resident is discharged or leaves the facility, ~~medications currently being administered shall be sent, in the original container, with the resident or with a responsible agent, and with the approval of the physician~~ the facility shall turn over to a responsible agent Schedule II medications and prescription medications currently being administered. The facility may send nonprescription medications with the child as needed. The facility shall document in the child's file:

a. The name, strength, dosage form, and quantity of each medication.

b. The signature of the facility staff person who turned over the medications to the responsible agent. c.

The signature of the responsible agent receiving the medications.

ITEM 80. Rescind subrule 114.12(10) and adopt the following **new** subrule in lieu thereof:

114.12(10) *Unused prescription drugs.* Unused prescription drugs prescribed for residents may not be kept at the facility for more 15 days after the resident has left the facility. The unused prescription drugs shall be destroyed by the facility executive director or the executive director's designee in the presence of at least one witness. Outdated, discontinued, or unusable nonprescription medications shall also be destroyed in a similar manner. The person destroying the medication shall document:

- a. The resident's name.
- b. The name, strength, dosage form, and quantity of each medication.
- c. The date the medication was destroyed.
- d. The names and signatures of the witness and staff person who destroyed the medication.

ITEM 81. Amend subrule 114.12(11) as follows:

114.12(11) *Refills.* Prescriptions shall be refilled only with the permission of the attending physician-prescriber authorized under Iowa law.

ITEM 82. Amend subrule 114.12(13) as follows:

114.12(13) *Order of physician-authorized prescriber.* No prescription medication may be administered to a resident without the order of a licensed physician-an authorized prescriber.

ITEM 83. Amend subrule 114.12(14) as follows:

114.12(14) *Patient reaction.* Any unusual patient reaction to a drug shall be reported to the attending physician or prescriber immediately.

ITEM 84. Amend subrule 114.12(16) as follows:

114.12(16) *Administration of drugs.* Medications shall be administered only in accordance with the instructions of the attending physician or authorized prescriber. ~~Controlled substances-Medications~~ shall be administered only by qualified personnel-staff who have completed a medication management course. The type and amount of the medication, the time and date, and the staff member administering the medication shall be documented in the child's record. (See IAC 620—8.16(204).)

ITEM 85. Amend subrule 114.12(17) as follows:

114.12(17) *Self-administration of drugs.* There shall be written policy and procedures relative to self-administration of prescription medications by residents and only when:

- a. Medications are prescribed by a physician or other authorized prescriber.
- b. The physician ~~agrees or~~ authorized prescriber provides written approval that the patient is capable of participating and can self-administer the drug.
- c. No change.

ITEM 86. Adopt the following **new** subrule 114.12(18):

114.12(18) *Obtaining nonprescription medications.* Facilities shall maintain a supply of standard nonprescription medications for use for children residing at the facility. Examples of standard nonprescription medications include cough drops and cough syrups, aspirin substitutes and other pain control medication, poison antidote, and diarrhea control medication.

- a. All nonprescription medications kept on the premises for the use of residents shall be preapproved annually by a licensed pharmacist or an authorized prescriber.
- b. Facilities shall maintain a list of all preapproved nonprescription medications. The list shall indicate standard uses, standard dosages, contraindications, side effects, and common drug interaction warnings. The facility administrator or the administrator's designee shall be responsible for determining the scope of the list and brands and types of medications included.
- c. Only nonprescription medications on the preapproved list shall be available for use. However, the facility administrator or the administrator's designee, in consultation with an authorized prescriber or licensed pharmacist, may approve use of a nonprescription medication that is not on the preapproved list for a specific child.

ITEM 87. Amend paragraph **114.13(3)“f”** as follows:

f. The child shall be allowed to send and receive mail unopened unless contraindicated. Contraindications, except those listed below, should be documented in the child’s file. The facility may require the child to open incoming mail in the presence of a staff member when it is suspected to contain contraband articles, or when there is money that should be receipted and deposited.

ITEM 88. Amend subrule 114.20(1) as follows:

114.20(1) Generally. The facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child’s family. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep. Discipline shall not be used for anyone other than a child whose actions resulted in consequences. Group discipline shall not be used because of actions of an individual child or other children.

ITEM 89. Amend subrule 114.20(3) as follows:

114.20(3) Physical restraint. The use of physical restraint shall be employed only to prevent the child from injury to self, to others, or to property. Physical restraint must be conducted with the child in a standing position whenever possible. Each child has the right to be free from restraint and seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

a. to c. No change.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child’s rights and to ensure safety shall be clearly ~~set forth~~ documented in the child’s record by the responsible staff persons no later than the end of the shift in which the restraint was used.

e. Documentation of restraint use shall include, but need not be limited to, the following:

(1) Each use of restraint or control room.

(2) The time the intervention began and ended.

(3) The reason that required the resident to be restrained or put in a control room.

(4) The name of staff involved in the intervention.

ITEM 90. Amend subrule 114.20(4) as follows:

114.20(4) Other restraints and control room. Only comprehensive residential facilities may use a control room, locked cottages, or mechanical restraints or chemical restraint.

ITEM 91. Adopt the following new subrule 114.20(6):

114.20(6) Time out.

a. A resident in time out must never be physically prevented from leaving the time out area. Time out may take place away from the area of activity or from other residents, such as in the resident’s room, or in the area of activity of other residents.

c. Staff must monitor the resident while the resident is in time out.

ITEM 92. Amend rule 441—114.21(237) as follows:

441—114.21(237) Illness, accident, death, or unauthorized absence from the facility.

114.21(1) Notification of illness. A facility shall notify the child’s parent(s), guardian and responsible agency of any serious illness, incident involving serious bodily injury, ~~or~~ circumstances causing removal of the child from the facility, or elopement.

114.21(2) No change.

This rule is intended to implement Iowa Code section 237.2.

ITEM 93. Amend rule 441—114.22(237) as follows:

441—114.22(237) Records. In the event of closure of a facility, children's records shall be sent to the department of human services for retention according to the department's records retention policy or the period defined in the department's contract for services, whichever is longer.

This rule is intended to implement Iowa Code section 237.2.

ITEM 94. Rescind rule 441—114.23(237) and adopt the following new rule in lieu thereof: **441—114.23(237) Unannounced visits.**

114.23(1) Frequency.

a. Time. At least one annual unannounced visit shall occur during periods of the day when the child would normally be in the facility and awake.

b. Activities. The visit shall include an assessment of, but not be limited to, the following areas:

- (1) Interaction between the staff and child.
- (2) Interaction between the children.
- (3) Discussion with the child about experiences in the facility.
- (4) A check on any previously cited deficiencies.
- (5) Overall impression of the facility.
- (6) Staff record checks.

c. Recommendation. The licensing staff shall recommend follow-up when needed.

114.23(2) Visits at other times may occur as a result of a self-reported incident or specific complaint.

ITEM 95. Renumber rule **441—114.24(237)** as **441—114.25(237)**.

ITEM 96. Adopt the following new rule 441—114.24(237):

441—114.24(237) Record check information. Record checks are required for any entity being considered for licensure or employment by a licensee on a facility campus where children reside to determine whether any founded child abuse reports or criminal convictions exist or whether the entity has been placed on a sex offender registry. The facility shall not employ any person who has been convicted of a crime involving the mistreatment or exploitation of a child. The facility shall not employ any person who has a record of a criminal conviction or founded child abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of licensure, volunteering or employment.

114.24(1) Procedure. Each entity being considered for licensure or employment shall be checked for all of the following:

- a.* Records with the Iowa central abuse registry, using the request for child and dependent adult abuse information form;
- b.* Records with the Iowa division of criminal investigation, using the department's criminal history record check form;

Records with the Iowa sex offender registry;

d. Records with the child abuse registry of any state where the person has lived during the past five years; and,

e. Fingerprints provided to the department of public safety for submission through the state criminal history repository to the United States Department of Justice, federal bureau of investigation, for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required for all entities considered for licensure or employment by a licensee on a facility campus where children reside. ~~Psychiatric-Medical Institutions for Children, as defined by Iowa Code Chapter 135H, are exempt from this requirement.~~

114.24(2) Evaluation of record. If an entity for which a background check is required has a record of founded child or dependent adult abuse, a criminal conviction, or placement on a sex offender registry, the department shall prohibit licensure or employment unless an evaluation determines that the abuse, criminal conviction, or placement on a sex offender registry does not warrant prohibition.

a. Scope. The evaluation shall consider the nature and seriousness of the founded child or dependent adult abuse or criminal conviction report in relation to:

- (1) The position sought or held,
- (2) The time elapsed since the abuse or crime was committed,
- (3) The degree of rehabilitation,
- (4) The likelihood that the person will commit the abuse or crime again, and
- (5) The number of abuses or crimes committed by the person.

b. Evaluation form. The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return the department's record check evaluation form within ten calendar days of the date of receipt to be used to assist in the evaluation.

114.24(3) Evaluation decision. The department shall conduct the evaluation and make the decision of whether or not the founded child or dependent adult abuse or criminal conviction warrants prohibition of licensure or employment by a licensee. The department shall issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee. Record check evaluations are valid for 30 days from the date the notice of decision is issued.

ITEM 97. Adopt the following new definition of "Locked cottage" in rule **441—115.2(237)**:

"*Locked cottage*" means an occupied comprehensive residential facility or an occupied unit of a comprehensive residential facility which is physically restrictive because of the continual locking of doors to prevent the children in care from leaving the facility.

ITEM 98. Amend rule **441—115.2(237)**, definitions of "Comprehensive residential facility" and "Secure facility," as follows:

"*Comprehensive residential facility*" means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual ~~treatment-service~~ plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, and mechanical restraints, ~~and chemical restraints~~ when these controls meet licensing requirements.

"*Secure facility*" means any comprehensive residential facility which employs, on a regular basis, locked doors or other ~~physical means building characteristics intended~~ to prevent children in care from leaving the facility without authorization. Secure facilities may only be used for children who have been adjudicated delinquent or placed pursuant to provisions of Iowa Code chapter 229.

ITEM 99. Amend subparagraph **115.4(2)"b"(1)** as follows:

(1) Provide at least weekly group or individually scheduled in-person conferences with each resident for whom the caseworker is responsible. More frequent in-person contact shall be provided if required in the ~~care service~~ plan.

ITEM 100. Amend subrule 441—115.4(237) as follows:

115.4(1) Number of Staff

a. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a ~~one to five~~ one to eight staff to child ratio ~~during prime programming time, at all times.~~

Rescind rule 441—115.5(237) and adopt the following new rule in lieu thereof:

441—115.5(237) Casework services. The facility shall have the internal capacity to provide individual, family and group counseling and shall provide, but not be limited to, casework dealing with crisis intervention, daily living skills, peer relationships, future planning and preparation for discharge.

ITEM 101. Amend subrule 115.6(4) as follows:

115.6(4) Use of restraint.

a. and b. No change.

c. A secure facility which uses ~~any form of restraint permitted by licensing standards,~~ other than physical restraint, shall ensure that all direct service staff are adequately trained in the following areas:

(1) The appropriate use and application or administration of each ~~approved-permitted~~ form of restraint.

(2) and (3) No change.

d. A secure facility shall continually review any ~~placement of use of a restraint on a child, in any form of restraint~~ other than physical restraint. The facility shall release the child from restraint immediately when the situation precipitating restraint no longer exists.

ITEM 102. Amend subrule 115.7(2) as follows:

115.7(2) Written policies. When a comprehensive residential ~~treatment~~-facility uses a control room as part of its treatment program, the facility shall have written policies regarding its use. The policy shall:

a. to c. No change.

d. Limit the utilization of the control room to one of the following two circumstances:

(1) The child's ~~care-service~~ plan includes and explains how this use of the control room fits into the ~~treatment-service~~ plan for the child.

(2) A ~~one-time one-time~~ placement in an emergency without a ~~care-service~~ plan outlining the rationale for its use. This treatment shall be included in the ~~care-service~~ plan for a second placement of a child in the control room.

ITEM 103. Amend subrule 115.7(4) as follows:

115.7(4) Use of control room. The control room shall be used only when a less restrictive alternative to quiet or ~~allow~~-allowing the child to gain control has failed and when it is in the ~~care-service~~ plan. The following policies shall apply to the use of the control room:

a. to e. No change.

f. A staff member shall always be ~~within hearing distance of~~ positioned outside of the control room, ~~the child shall be visually checked by the staff at least every 15 minutes, and each check shall be recorded.~~ Visual and auditory observations of the child's behavior and condition shall be recorded at five-minute intervals, and a complete written report shall be documented in the child's file by the end of the staff person's work shift.

g. and h. No change.

ITEM 104. Amend subrule 115.8(3) as follows:

115.8(3) ~~As one unit of treatment program~~ Policies. ~~When a facility utilizes Licensees utilizing a locked cottage as one unit of its treatment program,~~ it shall have and follow written policies for the locked cottage. The policies shall be provided to the child, the child's parents or guardian and, when the child has an attorney, the child's attorney at the time of admission. The policies shall include:

a. and b. No change.

c. ~~Requirement~~ Requirements for documentation in writing of particular behaviors of a particular child that led to the ~~locked cottage~~ placement.

d. to h. No change.

ITEM 105. Amend rule 441—115.9(237) as follows:

441—115.9(237) Mechanical restraint. When a facility uses mechanical restraints as a part of its treatment program, the facility shall have and follow written policies regarding their use. These policies shall be approved by the licensor prior to their use. The policies shall be available to clients, parents or guardians, and referral sources at the time of admission. Policies shall also be available to staff.

115.9(1) and 115.9(2) No change.

115.9(3) *In transporting children.* Notwithstanding paragraph 115.9(1) "d," mechanical restraint of a child in case of a secure facility while that child is being transported to a point outside the facility is permitted when there is a serious risk of the child exiting the vehicle while the vehicle is in motion. The facility shall place a written report on each use in the child's case record. This report shall document the necessity for the use of restraint. Seat belts are not considered mechanical restraints. Agency policies should encourage the use of seat belts while transporting children and comply with Iowa law.

This rule is intended to implement Iowa Code section 237.4.

ITEM 106. Renumber rule 441—115.10(237) as 441—115.12(237).

ITEM 107. Adopt the following new rule 441—115.10(237):

441—115.10(237) Restraint and control room use debriefing.

115.10(1) Initial discussion. Within a short time after the use of the restraint or control room, staff involved in an intervention and the resident must have a face-to-face discussion except when the presence of a particular staff person may jeopardize the well-being of the resident.

a. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s).

b. The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of the restraint or control room and strategies to be used by the staff, the resident, or others that could prevent the future use of the restraint or control room.

115.10(2) Staff discussion. Within 24 hours after the use of the restraint or control room, all staff involved in the intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of the intervention including, but not limited to, the following:

(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention;

(2) Alternative techniques that might have prevented the use of the restraint or control room;

(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of the restraint or control room; and

(4) The outcome of the intervention, including any injuries that may have resulted from the use of the restraint or control room.

115.10(3) Documentation. Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, the names of staff who were excused from the debriefing, and any reasons that are applicable.

ITEM 108. Adopt the following new rule 441—115.11:

441—115.11(237) Chemical restraint. Chemical restraint shall not be utilized in a comprehensive residential facility and each comprehensive residential facility shall have written policies that clearly prohibit the use of chemical restraint.

ITEM 109. Amend 441—Chapter 116, title, as follows:

LICENSING AND REGULATION OF RESIDENTIAL FACILITIES
FOR CHILDREN WITH AN INTELLECTUAL DISABILITY OR BRAIN INJURY

ITEM 110. Amend rule 441—116.1(237) as follows:

441—116.1(237) Applicability. This chapter relates specifically to the licensing and regulation of residential facilities serving children with an intellectual disability or brain injury. Refer to 441—Chapter 112 for basic licensing and regulation of all foster care facilities, 441—Chapter 114 for definitions and minimum standards for all group living foster care facilities ~~including community care facilities~~; and 441—Chapter 115 for definitions and standards for comprehensive residential facilities for children. Chapters 112 and 114 apply to community residential facilities for children with an intellectual disability or brain injury and Chapters 112, 114 and 115 apply to comprehensive residential facilities for children with an intellectual disability or brain injury with the exception of the areas discussed specifically in this chapter.

This rule is intended to implement Iowa Code chapter 237.

ITEM 111. Amend rule **441—116.2(237)**, definitions of “Community residential facility for children with an intellectual disability” and “Comprehensive residential facility for children with an intellectual disability,” as follows:

“*Community residential facility for children with an intellectual disability or brain injury*” means a community residential facility as defined in rule 441—114.2(237) which serves children with an intellectual disability as defined in Iowa Code chapter 222 or brain injury as defined in Iowa Code chapter 225C.

“*Comprehensive residential facility for children with an intellectual disability*” means a comprehensive residential facility as defined in rule 441—115.2(237) which serves children with an intellectual disability as defined in Iowa Code chapter 222 or brain injury as defined in Iowa Code chapter 225C.

ITEM 112. Amend rule 441—116.5(237) as follows:

441—116.5(237) Program components. In addition to the requirements of 441—subrule 114.8(3), the facility shall ~~define in writing~~ have and follow a written procedure that defines who is responsible for overseeing personal hygiene of children and maintaining general orderliness of the facility.

This rule is intended to implement Iowa Code section 237.3.

ITEM 113. Amend rule 441—116.6(237) as follows:

441—116.6(237) Restraint. In addition to the provisions of 441—Chapters 114 and 115, a restraint may be used as stated in the child’s individual ~~care-service~~ plan as approved by the parent or guardian, caseworker, and facility as long as that facility meets the standards for utilizing that particular type of restraint.

This rule is intended to implement Iowa Code section 237.4.

Comments and Responses on ARC 105
Juvenile Detention and Shelter Care Homes
Received September 17, 2019

The following person/organization provided written comments, which are included in the summary below:

1. Steve Michael, Division Administrator, Division of Criminal and Juvenile Justice Planning
2. Emily Blomme, Chief Executive Officer, Foundation 2
3. Kristie Oliver, Executive Director, The Coalition

COMMENT:

Item 3: Eliminating “prime programming”

RESPONSE: DHS has eliminated the definition of “prime programming time” as follows:

Rescind the definitions of “Controlled substances,” “Family shelter home” and “Prime programming time” in rule 441—105.1(232).

COMMENT:

Item 8: Amend Administrative Code 105.5.(1)(d) to require a minimum of one staff person awake in each living unit and to ensure a minimum staff/child ratio of 1:16 is maintained in juvenile detention facilities.

RESPONSE:

DHS agrees. The change was made to ensure a 1:16 staff/child ratio is maintained, as follows:

d. Night hours. At night, there shall be a staff person awake in each living unit and making regular visual checks throughout the night. The visual checks shall be made at least every hour in shelter care and every half hour in detention. A log shall be kept of all checks, including the time of the check and any significant observations. The minimum staff-child ratio must be maintained at 1:16 during the overnight shift. ~~There shall be an on-call system which allows backup within minutes for both child care staff and casework personnel.~~

COMMENT: (2comments)

Item 6: “tested for tuberculosis and have had a physical examination within six months prior to hiring” could lead to complications. Currently, if someone from another agency

applies and has documentation that they have had a TB test and physical in the last three years (and can produce documentation), we do not need to send them.

RESPONSE:

DHS agrees. This change was made, as follows:

105.3(2) Health of employees. Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties tested for tuberculosis and have had a physical examination within six months prior to hiring, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous 3 years. A statement attesting to these facts shall be secured at the time of employment and filed in the personnel records of the staff person. A new statement shall be secured at least every three years. Physical examinations shall be completed at least every three years thereafter, or whenever circumstances require them more frequently. Evidence of these examinations or tests shall be included in each personnel file. The statement shall be signed examinations or tests shall be completed by one of the following:

- a. to c. No change.

COMMENT:

Item 8: Requiring Coed staff creates staffing challenges, including an agency of potentially needing to specifically post hiring ads for staff of a particular sex in order to meet this requirement. Some staff identify as gender fluid or may be transgender, which adds additional challenges to meeting this requirement.

RESPONSE:

DHS agrees that this particular hardship for agencies can be remedied by striking the sex/gender requirement of staff, as follows:

105.5(1) Number of staff.

a. *Generally.* A sufficient number of child care or house parent staff shall be on duty at all times so as to provide adequate coverage. The number of staff required will vary depending on the size and complexity of the program. All facilities shall have at least one staff person on duty. Facilities having six or more residents shall have at least two staff persons on duty at all times that children are usually awake and present in the facility. A minimum staff-to-child ratio of one child care worker to five children shall be maintained at all times children are awake and present in the facility and during supervised outings. Coed facilities having more than five residents should have both male and female staff on duty at all times. All child care or house parent staff shall be at least 18 years of age.

COMMENT:

Item 8: The changes add a requirement that the on-call system be operational 24 hours a day to provide supervisory consultation. Was the fiscal impact on providers considered when making the changes to the on-call system rule?

RESPONSE:

DHS agrees that the fiscal cost associated with a 24 hour/day consultation has a significant cost and is not necessary to meeting the needs of the youth placed in the facility. A change was made as follows:

105.5(1) Number of staff.

a. *Generally.* A sufficient number of child care ~~or house parent~~ staff shall be on duty at all times so as to provide adequate coverage. The number of staff required will vary depending on the size and complexity of the program. All facilities shall have at least one staff person on duty. ~~Facilities having six or more residents shall have at least two staff persons on duty at all times that children are usually awake and present in the facility. A minimum staff-to-child ratio of one child care worker to five children shall be maintained at all times children are awake and present in the facility and during supervised outings. Coed facilities having more than five residents should have both male and female staff on duty at all times.~~ All child care ~~or house parent~~ staff shall be at least 18 years of age.

b. *On-call system.* ~~There shall be an on-call system for coed facilities to provide that staff of the same sex as the resident shall perform the following: There shall be an on-call system to provide supervisory consultation. There shall be a written plan documenting this system.~~

COMMENT:

Item 9: This change in rule requires the agency to request information if it has not been sent by DHS.

RESPONSE:

DHS is still responsible for sending the information – and has policies and procedures in place to require as such. If the shelter does not receive the information though, the expectation will be that said information is requested. No change to proposed rule.

COMMENT: (2 comments)

Item 12: Agencies using the school lunch program are assumed to be meeting the dietary requirements of these rules.

RESPONSE:

Residents of shelters must have their dietary needs met by the facilities, which may include special requirements as determined by medical personnel and/or dietitians. No change to proposed rule.

COMMENT:

Item 24: Timeframes for placement in shelter are described as 30 days or less, but the new federal expectation is 14 days or less.

RESPONSE:

Agreed that the rule should include a target of 14 days or less, in keeping with the spirit of the Family First Act. DHS is not in agreement that a maximum length of stay not to exceed 45 days should be written into rules. Changes to proposed rules are as follows:

441—105.18(232) Discharge. Children in shelter care should be discharged to, preferably, a permanent placement, or, alternatively, a lower level of care in a family-like setting, at the earliest possible time, preferably within 14 days. The facility shall collaborate with referral workers to assess each child's need for ongoing placement and the reasons for longer stays shall be documented in the child's case file. Children in detention shall be discharged as determined by the court.

COMMENT:

ITEM 28. Amend paragraph 105.21(1)"d" to eliminate the use of restrains on known pregnant juveniles in order to ensure compliance with Federal Juvenile Justice Reform Act of 2018.

RESPONSE:

DHS agrees and made the amendment to section 16, in order to be in compliance with Federal requirements, as follows:

105.16(3)e. A child known to be pregnant may not be restrained during labor, delivery, and post-partum recovery, unless credible, reasonable grounds exist to believe the detainee presents an immediate and serious threat of hurting herself, staff, or others.

Comments and Responses on ARC 114
Licensing and Regulation of All Group Living Foster Care Facilities for Children
Received September 17, 2019

The following person/organization provided written comments, which are included in the summary below:

1. Chris Koeplin, Executive Director, YHMA
2. Debbie Orduna, Director, Boystown
3. Kristie Oliver, Executive Director, The Coalition

COMMENT: (2 comments)

Item 48 does indeed have significant fiscal Impact in direct dissonance with the Fiscal Impact statement attached to the Notice of Intended Action.

RESPONSE:

DHS does not anticipate eliminating “prime programming” as increasing fiscal impact. Minimum staff/child ratios are defined in the contract, which are required when youth are present in the program. Contractors are also required to provide staff at the ratio needed to meet needs of youth in the program. Prime Programming has been irregularly defined and not enforceable. Removing this definition creates more flexibility to contractors without compromising safety of children.

COMMENT: General comment that the process of getting fingerprints completed is challenging and impacting the workforce.

RESPONSE:

DHS is aware of the challenges getting fingerprint checks returned in a timely manner. This Administrative Rule is a result of the federal requirement under the Family First Act and the legislative change to Iowa Code made last session. DHS understands the concerns and is actively working on a solution with the Department of Public Safety to expedite the process.

COMMENT:

Item 57: The language “tested for tuberculosis and have had a physical examination within six months prior to hiring” could lead to complications. Currently, if someone from another agency applies and has documentation that they have had a TB test and

physical in the last three years (and can produce documentation), we do not need to send them.

RESPONSE:

DHS agrees. This change was made as follows:

114.7(2) Health of staff. Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties be tested for tuberculosis and have a physical examination within six months prior to hiring. Physical examinations shall be completed every three years thereafter, unless the staff can produce valid documentation of the physical and tuberculosis test from within the previous 3 years. A statement attesting to these facts shall be secured at the time of employment and filed in the staff record of the staff person. A new statement shall be secured at least every three years. Evidence of these examinations or tests shall be included in each personnel file. The statement shall be signed examinations or tests shall be completed by one of the following:

- a. to c. No change.

COMMENT:

Item 59. While the amendment to 114.8(2)d takes out the prime programming time and sets the ratio at one to eight staff to client, there is not a subsequent amendment to the corresponding section – 115.4(1) – Number of staff. – where it still states “There shall be at least a one to five staff to child ratio during prime programming time.” Without a definition of prime programming time any longer (Item 48 deletes it), this doesn’t make sense.

RESPONSE:

DHS agrees. This change was described in the document containing comments to chapter 15.

COMMENT:

Item 63: This change in rule requires the agency to request information if it has not been sent by DHS. Language in the rule was modified due to this comment.

RESPONSE:

DHS is still responsible for sending the information – and has policies and procedures in place to require as such. If the shelter does not receive the information though, the expectation will be that said information is requested. No change to proposed rule.

COMMENT:

Item 68: Agencies using the school lunch program are assumed to be meeting the dietary requirements of these rules.

RESPONSE:

Residents of shelters must have their dietary needs met by the facilities, which may include special requirements as determined by medical personnel and/or dieticians.

COMMENT:

Item 75: The language allows too much DHS access to information for children who may not even be in the facility due to a DHS contract.

RESPONSE:

The allowable information will be limited to children in the facility as a result of a DHS contract.

Comments and Responses on ARC 115
Licensing and Regulation of Comprehensive Residential Facilities for Children
Received September 17, 2019

The following person/organization provided written comments, which are included in the summary below:

1. Kristie Oliver, Executive Director, The Coalition
2. Chris Koeplin, Executive Director, YHMA

COMMENT: (2 comments)

Item 59. While the amendment to 114.8(2)d takes out the prime programming time and sets the ratio at one to eight staff to client, there is not a subsequent amendment to the corresponding section – 115.4(1) – Number of staff. – where it still states “There shall be at least a one to five staff to child ratio during prime programming time.” Without a definition of prime programming time any longer (Item 48 deletes it), this doesn’t make sense.

RESPONSE:

DHS agrees that striking language about “prime programming time” in 115.4(1) must occur. This change was made as follows:

d. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff to client ratio during prime programming time all times children are awake and present in the facility and during supervised outings.

COMMENT:

Item 98: The commenter acknowledges only adjudicated delinquent youth can be placed in a locked secure facility and goes on to ask, “Which rule supersedes the other?”

RESPONSE:

Per the commenter’s question, the definition of a secure facility is slightly modified to provide further clarification. It is not clear what other rule the commenter is referencing as it pertains to which rule supersedes, but suffice to say, providers are encouraged to consult DHS when apparent conflicts in rule chapters arise. Proposed definitions of “Comprehensive residential facility” and “Secure facility,” in Chapter 115 are modified as follows:

“Comprehensive residential facility” means a facility which provides care and

treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual ~~treatment~~ service plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, and mechanical restraints, ~~and chemical restraints~~ when these controls meet licensing requirements.

“Secure facility” means any comprehensive residential facility which employs, on a regular basis, locked doors or other ~~physical means~~ building characteristics intended to prevent children in care from leaving the facility without authorization. Secure facilities may only be used for children who have been adjudicated delinquent or placed pursuant to provisions of Iowa Code chapter 229.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Jim Chesnik	Telephone Number 281-9368	Email Address jchesni@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

These changes clean up obsolete portions of the rules, bring better alignment to current practice, and implement changes required by federal law.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Code of Iowa Chps. 237 and 232.

3. Describe who this rulemaking will positively or adversely impact.

Providers of foster group care services and emergency juvenile shelter care.

4. Does this rule contain a waiver provision? If not, why?

No. All providers of these services are required to be licensed or approved. These administrative rule chapters are all associated with either licensure or approval.

5. What are the likely areas of public comment?

Potentially any of the changes proposed to licensure standards, even though they essentially clarify requirements. The new federal fingerprinting requirements for background checks may be controversial even though fingerprinting has been required for foster parent licensure for many years. Going forward they will be required for group care and emergency juvenile shelter also.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

The background checks in these licensure or approval standards could prohibit licensure or employment of persons with criminal or abuse histories. The number of potential jobs or the costs that would result from implementation are unknown.



Administrative Rule Fiscal Impact Statement

Date: February 22, 2019

agency:	Human Services
AC citation:	441 IAC -Chps 105, 112, 114, 115, 116
agency contact:	Jim Chesnik
Summary of the rule: These changes clean up obsolete portions of the rules, bring better alignment to current practice, and implement changes required by federal law.	
<i>Fill in this box if the impact meets these criteria:</i> <input type="checkbox"/> No fiscal impact to the state. <input checked="" type="checkbox"/> Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years. <input type="checkbox"/> Fiscal impact cannot be determined.	
Brief explanation: This rule makes a number of changes, most of which are clean up or clarification which will have no fiscal impact. A component of the change that will have a fiscal impact relates to fingerprinting checks. Federal law changes will now require fingerprinting checks for group care and emergency juvenile shelter. DHS intends to pay the cost of the fingerprint checks, but at this point we do not have a clear idea of how much that will be. The estimation is that it will total anywhere from \$76,000-\$96,000. An informal accounting of staff completed in 2018 yielded approximately 1,900 staff. It is estimated this will cost \$40 per check. Estimating a 25% staff turnover equates to an additional 500 checks, for a total estimation of 2,400 checks in Year 1. We would then assume 500 checks per year, on an ongoing basis. SFY20 \$40 per check, Estimation of 1,900 current staff, also including 500 more staff for possible staff turnover. Equates to 2,400 staff at \$40 per check, which is \$96,000. SFY21 \$40 per check, estimation of 500 staff for possible turnover at \$40 per check, which is \$20,000.	
<i>Fill in the form below if the impact does not fit the criteria above:</i> Fiscal impact of \$100,000 annually or \$500,000 over 5 years.	
Assumptions:	
Describe how estimates were derived:	

Estimated Impact to the State by Fiscal Year

	<u>Year 1 (FY 20)</u>	<u>Year 2 (FY 21)</u>
Revenue by each source:		
General fund	0.00	0.00
Federal funds	0.00	0.00
Other (specify):	0.00	0.00
TOTAL REVENUE	0.00	0.00
Expenditures:		
General fund	96,000.00	20,000.00
Federal funds	0.00	0.00
Other (specify):	0.00	0.00
TOTAL EXPENDITURES	96,000.00	20,000.00
NET IMPACT	-96,000.00	-20,000.00

This rule is required by state law or federal mandate.
Please identify the state or federal law:
 Identify provided change fiscal persons:
 Family First Prevention Services Act, Public Law 115-123

Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
 If additional funding is not provided, the cost will need to be absorbed within the Child and Family Services appropriation.

Fiscal impact to persons affected by the rule:

The background checks in these licensure or approval standards could prohibit licensure or employment of persons with criminal or abuse histories. The number of potential jobs or the costs that would result from implementation are unknown.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

None anticipated.

Agency representative preparing estimate: David Philmon
 Telephone number: 515-281-6856

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rule making related to the monthly standard deduction for personal care services at a residential care facility and providing an opportunity for public comment

The Department of Human Services hereby proposes to amend Chapter 75, “Conditions of Eligibility,” Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249.12.

Purpose and Summary

This proposed rule making will continue to allow an annual change in the statewide monthly standard deduction for personal care services provided in a licensed residential care facility (RCF) based on the Consumer Price Index (CPI) for All Urban Consumers. This annual change continues to benefit medically needy members who reside in licensed RCFs because it continues to allow personal care needs to be applied to the spenddown obligation.

Fiscal Impact

There is minimal fiscal impact expected as a result of this rule making.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Public Comment

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on November 26, 2019. Comments should be directed to:

Nancy Freudenberg
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: appeals@dhs.state.ia.us

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)“b,” an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written

request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making action is proposed:

Amend subparagraph **75.1(35)“g”(2)** as follows:

(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)~~ by multiplying the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics. ~~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.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Karen Jones	Telephone Number 515-281-8635	Email Address kjones2@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

The average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed Residential Care Facility (RCF) are allowed as a deduction for the Medically Needy coverage group spenddown. This deduction was based on the average per day rate of health care costs associated with RCFs participating in the state supplementary assistance program for a 30.4 day month as computed from submitted cost reports. This deduction is applied to the members Medically Needy spenddown. When the spenddown is met, the member becomes Medicaid eligible for the certification period.

Due to the amendment of Iowa Code 249.12, which eliminates the requirement for privately operated licensed Residential Care Facilities (RCFs) to complete and submit annual cost reports, the Department is changing how they determine the average statewide monthly standard deduction for personal care services.

The Department decided we will multiply the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index (CPI) for Urban Consumers as published by the Bureau of Labor Statistics to calculate the current year's deduction for personal care services.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Iowa Code 249.12

3. Describe who this rulemaking will positively or adversely impact.

This rulemaking will continue to allow an annual change in the average statewide monthly standard deduction for personal care services provided in a licensed RCF based on the CPI for Urban Consumers. This annual change continues to be a benefit to the Medically Needy member who resides in a licensed RCF because it continues to allow the personal care services to be applied toward spenddown obligations.

4. Does this rule contain a waiver provision? If not, why?

No. This amendment does not contain waiver provisions because it confers a benefit. Individuals may request an exception pursuant to the Department's general rule on exceptions to policy at 441 IAC 1.8.

5. What are the likely areas of public comment?

Public comment on the change on how we calculate the average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed RCF is unlikely since the amendment to the rule will continue to result in an annual change.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

No.



Administrative Rule Fiscal Impact Statement

Date: April 22, 2019

Agency: Human Services
IAC citation: 441 IAC 75.1(35)"g"(2)2
Agency contact: Karen Jones

Summary of the rule:

Due to the amendment of Iowa Code 249.12, which eliminates the requirement for privately operated licensed Residential Care Facilities (RCFs) to complete and submit annual cost reports, the Department is changing how they determine the average statewide monthly standard deduction for personal care services by multiply the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index (CPI) for Urban Consumers as published by the Bureau of Labor Statistics.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
 Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
 Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

It is not anticipated that this change in calculating the deduction will provide much of a different result compared to the old way of calculating the deduction. As previous, the rate could go up or down. Here is an example of the amount of the change for 2019 using the new calculation:

2018 allowable deduction: \$25.96 per day, \$789.18 per month
CPI-U for 12 months ending December 2018: 1.9%

$\$25.96(0.019)=0.49324$ (rounded up to \$0.50)
 $\$25.96+\$0.50=\$26.46$
 $\$26.46(x\ 30.4)=\804.384 (rounded up to \$804.39)

The above increase equates to \$.50 per day increase for 2019, or a difference of \$15.21 per month.

The prior year's rate was \$24.49 per day and \$744.50 per month. Compared to the current rate of \$25.96, this resulted in a difference of \$1.47 per day and \$44.68 per month.

The rate in the prior year to that was \$23.40 per day and \$711.36 per month. Compared to the previous rate of \$24.49, this resulted in a difference of \$1.09 per day and \$33.00 per month.

Fill in the form below if the impact does not fit the criteria above:

- Fiscal impact of \$100,000 annually or \$500,000 over 5 years.

Funding has not been provided for the rule.

Please explain how the agency will pay for the rule change:

Not applicable as the rule change will continue to result in an annual change with minimal impact.

Fiscal impact to persons affected by the rule:

Minimal impact. This rulemaking will continue to allow an annual change in the average statewide monthly standard deduction for personal care services provided in a licensed RCF based on the CPI for Urban Consumers. This annual change continues to be a benefit to the Medically Needy member who resides in a licensed RCF because it continues to allow the personal care services to be applied toward spenddown obligations.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

No impact.

Agency representative preparing estimate: Jason Buls

Telephone number: 515-281-5764

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

**Proposing rule making related to Medicaid payments to nursing facilities
and providing an opportunity for public comment**

The Human Services Department hereby proposes to amend Chapter 81, "Nursing Facilities," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

The Department proposes these amendments in order to provide clarification on the treatment of depreciation when a change of nursing facility ownership occurs. The proposed amendments also clarify leasing arrangements, update the Iowa Medicaid Enterprise (IME) mailing address, and make changes to reflect current operations of the IME.

Fiscal Impact

Without having all of the lessors' financial data related to ownership of the facilities in leasing arrangements and comparing to lease expenses being paid by the facilities, it would be impossible to determine what the impact of these rules would be on the facilities. However, given the scope of the change coupled with the fact that providers do not receive

reimbursement at full cost through their per diem, the rule is expected to have a relatively minimal impact.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Public Comment

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on November 26, 2019. Comments should be directed to:

Nancy Freudenberg
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: appeals@dhs.state.ia.us

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)“b,” an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Amend subrule 81.6(6) as follows:

81.6(6) *Census of ~~public-assistance recipients~~ Medicaid members*. Census figures of ~~public-assistance recipients~~ Medicaid members shall be obtained on the last day of the month ending the reporting period.

ITEM 2. Rescind paragraph **81.6(11)“j”** and adopt the following **new** paragraph in lieu thereof:

j. For financial and statistical reports received after [the effective date of these rules], the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association Useful Life Guide.

(2) Limitation — full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.6(12).

ITEM 3. Rescind paragraph **81.6(11)“m”** and adopt the following **new** paragraph in

lieu thereof:

m. For financial and statistical reports received after [the effective date of these rules], the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.6(11) "l," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11) "j" plus the landlord's other expenses; or

2. Actual rent payments.

ITEM 4. Amend subparagraph **81.6(16) "h" (5)** as follows:

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, ~~100 Army Post Road~~ P.O. Box 36450, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. to 3. No change.

ITEM 5. Rescind paragraph **81.10(4)“h”** and adopt the following new paragraph in lieu thereof:

h. Ventilator patients.

(1) Definition. For purposes of this paragraph only, “ventilator patients” means Medicaid-eligible patients who, as determined by the Quality Improvement Organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) Reimbursement. In-state nursing facilities shall receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.6(16)“f”(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

ITEM 6. Amend paragraph **81.10(5)“a”** as follows:

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry

out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to ~~441—subparagraph 78.10(2)“a”(4)~~, 441—paragraph 78.10(2)“d,” medical supplies except for those listed in ~~441—paragraph 78.10(4)“b,”~~ oxygen except under circumstances specified in ~~441—paragraph 78.10(2)“a,”~~ and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician, ~~except for those specified in 441—paragraph 78.1(2)“f.”~~

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

ITEM 7. Amend paragraph **81.13(5)“e”** as follows:

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, ~~written and telephone communications~~, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) The facility must respect the resident’s right to personal privacy, including the right to privacy in the resident’s oral (that is, spoken or sign language), written, and electronic communications.

~~(2)~~ (3) Except as provided in subparagraph ~~(3)~~(4) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

~~(3)~~ (4) The resident’s right to refuse release of personal and clinical records does not apply ~~when the resident is transferred to another health care institution or record release~~

~~is required by law. to the following:~~

● The release of personal and clinical records to a health care institution to which the resident is transferred; or

● A record release that is required by law.

ITEM 8. Rescind paragraph **81.13(5)“i”** and adopt the following **new** paragraph in lieu thereof:

i. Mail. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident, whether delivered by a postal service or by other means, including the right to:

(1) Privacy of such communications consistent with this section; and

(2) Access to stationary, postage, and writing implements at the resident’s own expense.

ITEM 9. Adopt the following **new** paragraph **81.13(5)“q”**:

q. Electronic communication. The resident has the right to have reasonable access to and privacy in the resident’s use of electronic communications, including, but not limited to, email and video communications, and for Internet research:

(1) If accessible to the facility;

(2) At the resident’s expense, if any additional expense is incurred by the facility to provide such access to the resident; and

(3) To the extent that such use may comply with state and federal law.

ITEM 10. Amend subparagraph **81.13(9)“b”(7)** as follows:

(7) Automated data processing requirement.

1. to 3. No change.

4. The facility must transmit MDS data in the ~~ASCH~~ format specified by CMS.



Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist Sally Oudekerk	Telephone Number 515-256-4643	Email Address soudeke@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:
 The department has promulgated these rules in order to provide clarification on of the treatment of depreciation when a change of ownership occurs and leasing arrangements. The rules also serve to align with current federal regulations related to resident rights. The department is also updating the Iowa Medicaid Enterprise (IME) mailing address and making changes to language to reflect current operations of the IME.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):
 Iowa Code 249A.4

3. Describe who this rulemaking will positively or adversely impact.
 The changes to the property costs will adversely affect facilities with lease arrangements as possibly not recognizing all costs in the lease agreement.

4. Does this rule contain a waiver provision? If not, why?
 Specific waivers are not provided because the department has an established procedure for considering exceptions to policy. A waiver of any of these rules may be granted through that process

5. What are the likely areas of public comment?
 Providers will likely comment on these changes as they may see them as an attempt to adversely affect their per diem/reimbursement rate, as opposed to a clarification of the rule for the previously intended purpose.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)
 These rules should not have an impact on private-sector jobs and employment opportunities in Iowa.



Administrative Rule Fiscal Impact Statement

Date: June 20, 2019

Agency: Human Services

IAC citation: 441 IAC 81.6

Agency contact: Sally Oudekerk

Summary of the rule:

The department has promulgated these rules in order to provide clarification on of the treatment of depreciation when a change of ownership occurs and leasing arrangements. The rules also serve to align with current federal regulations related to resident rights. The department is also updating the Iowa Medicaid Enterprise (IME) mailing address and making changes to language to reflect current operations of the IME.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
- Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
- Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

Some providers could see a decrease in their per diem payment rate due to the rule update. The rule update seeks to clarify expenses from leasing arrangements that can be included in reimbursable cost and a standard way to calculate a reasonable rate of return for cost reporting. It is not changing how depreciation is calculated. The change to property costs could, however, adversely affect facilities with lease arrangements by not recognizing all costs.

Without having all of the lessor's financial data related to ownership of the facilities in leasing arrangements and comparing to lease expenses being paid by the facilities, it would not be possible to determine what an impact would be. However, given the scope of the change coupled with the fact that providers do not receive reimbursement of full cost through their per diem, the rule update is expected to have a relatively minimal impact.

Per diem rates are set based on allowable costs on the submitted cost reports, but would have no impact on the services provided to the residents.

Fill in the form below if the impact does not fit the criteria above:

- Fiscal impact of \$100,000 annually or \$500,000 over 5 years.

Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
The impact is expected to be minimal.

Fiscal impact to persons affected by the rule:

The change to property costs could adversely affect facilities with lease arrangements by not recognizing all costs, but the aggregate impact is expected to be minimal.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

No fiscal impact.

Agency representative preparing estimate: Jason Buis

Telephone number: 515-281-5764

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

**Proposing rule making related to case management services
and providing an opportunity for public comment**

The Human Services Department hereby proposes to amend Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 83, "Medicaid Waiver Services," and to rescind Chapter 90, "Targeted Case Management," and adopt a new Chapter 90, "Case Management Services," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

This rule making proposes to adopt a new Chapter 90 that clarifies the case management service activities received by various populations in the Medicaid program and includes a definition of and references to a core standardized assessment (CSA) as required under the Balancing Incentive Program (BIP). BIP was created as part of the federal Patient Protection and Affordable Care Act. Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Acts, chapter 138, section 142(20). In addition, new Chapter 90 outlines and requires billable activities for fee-for-service members, includes a requirement for provider reporting of minor incidents, and includes the person-centered service planning definition and service requirements. Updates to cross-reference citations in other chapters that are affected by this rule making are also proposed.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Public Comment

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on November 26, 2019. Comments should be directed to:

Nancy Freudenberg
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: appeals@dhs.state.ia.us

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)“b,” an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Amend paragraph **78.27(6)“a”** as follows:

a. Scope. Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 2. Amend paragraph **78.37(17)“a”** as follows:

a. Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 3. Amend paragraph **78.43(1)“a”** as follows:

a. Case management services shall be provided as set forth in rules ~~441—90.5(249A) and 441—90.8(249A)~~ 441—90.4(249A) through 441—90.7(249A).

ITEM 4. Rescind and reserve paragraph **83.22(2)“a.”**

ITEM 5. Rescind 441—Chapter 90 and adopt the following **new** chapter in lieu thereof:

CHAPTER 90
CASE MANAGEMENT SERVICES

PREAMBLE

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services. The term “case management” encompasses targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination.

441—90.1(249A) Definitions.

“*Adult*” means a person 18 years of age or older on the first day of the month in which service begins.

“*Care coordination*” means the case management services provided by an integrated health home to members who are also receiving home- and community-based habilitation services pursuant to rule 441—78.27(249A) or HCBS children’s mental health waiver services pursuant to rules 441—83.121(249A) through 441—83.129(249A).

"Case manager" means the staff person providing case management services regardless of the entity providing the service or the program in which the member is enrolled.

"Child" means a person other than an adult.

"Chronic mental illness" means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found at rule 441—24.1(225C). For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Community-based case manager" means the employee of a Medicaid-contracted managed care organization (MCO) who provides case management services to MCO-enrolled members.

"Core standardized assessment" or *"CSA"* means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant's or member's needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs. The core standardized assessment shall be performed by a contractor under the direction of the department for the fee-for-service population. MCOs shall perform core standardized assessments for MCO-enrolled members.

"Department" means the department of human services.

"Developmental disability" means a severe, chronic disability that is determined through professionally administered screening and evaluations and that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care, (b) receptive and expressive language, (c) learning, (d) mobility, (e) self-direction, (f) capacity for independent living, and (g) economic self-sufficiency; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization because the member is exempt from managed care organization enrollment.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act.

"Integrated health home" or *"IHH"* means a provider of health home services that is a Medicaid-enrolled provider and that is determined through the provider enrollment process to have the qualifications, systems and infrastructure in place to provide IHH services pursuant to rule 441—77.47(249A). IHH covered services and member eligibility for IHH enrollment are governed by rule 441—78.53(249A). The IHH provides case management services for enrolled IHH members.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in rule 441—83.61(249A).

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F; or

6. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"*Managed care organization*" or "*MCO*" means the same as defined in rule 441—73.1(249A).

"*Medical institution*" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 Code of Federal Regulations Section 435.1009. A residential care facility is not a medical institution.

"*Member*" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"*Minor incident*" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that is not a major incident but 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.

"*Person-centered service plan*" or "*service plan*" means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or family, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"*Rights restriction*" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

"*Targeted case management*" means case management services furnished to assist members who are part of a targeted population.

"*Targeted population*" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or
2. A child who is eligible to receive HCBS intellectual disability waiver services or HCBS children's mental health waiver services according to 441—Chapter 83.

441—90.2(249A) Targeted case management.

90.2(1) Eligibility for targeted case management. A person who meets all of the following criteria shall be eligible for targeted case management:

- a. The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35);
- b. The person is a member of a targeted population;
- c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);
- d. The person has applied for targeted case management in accordance with the policies of the provider;
- e. The person's need for targeted case management has been determined in accordance with rule 441—90.2(249A);
- f. The person is not eligible for, or enrolled in, Medicaid managed care; and
- g. If the person is also receiving HCBS habilitation services pursuant to rule 441—78.27(249A) or HCBS children's mental health waiver services pursuant to rules 441—83.121(249A) through 83.129(249A), the person is not enrolled in an integrated health home pursuant to rule 441—78.53(249A).

90.2(2) Determination of need for targeted case management. Assessment at least every 365 days of the need for targeted case management is required as a condition of eligibility under the medical assistance program. The targeted case management provider shall determine the member's initial and

ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

- a. The member has a need for targeted case management to manage necessary medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member;
- b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services; and
- c. The member is not receiving, under the medical assistance program or under a Medicaid managed health care plan, other paid benefits that serve the same purpose as targeted case management or integrated health home care coordination.

90.2(3) Application for targeted case management. The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit if other services outside the scope of case management are needed or requested.

a. *Application process and documentation.* The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. For FFS members, the provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management services agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

b. *Application decision.* The case manager shall inform the applicant, or the applicant's representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements at 441—subrule 7.7(1).

c. *Denial of applications.* The case manager shall deny an application for service when:

- (1) The applicant is not currently eligible for Medicaid;
- (2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);
- (3) The applicant, or the applicant's representative, withdraws the application;
- (4) The applicant does not provide information required to process the application;
- (5) The applicant is receiving duplicative targeted case management or integrated health home care coordination from another Medicaid provider; or
- (6) The applicant does not have a need for targeted case management.

90.2(4) Transition to a community setting. Managed care organizations must provide transition services to all enrolled members. Fee-for-service targeted case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management and is a member of a targeted population. Transitional case management is not an allowable service for other HCBS programs or populations;

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning;

c. The amount, duration, and scope of case management services shall be documented in the member's service plan, which must include case management services before and after discharge, to facilitate a successful transition to community living;

d. Payment shall be made only for services provided by Medicaid-enrolled targeted case management providers; and

e. Claims for reimbursement for case management services shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

441—90.3(249A) Termination of targeted case management services.

90.3(1) Targeted case management shall be terminated when:

- a. The member does not meet eligibility criteria under rule 441—90.2(249A);
- b. The member has achieved all goals and objectives of the service;

- c. The member has no ongoing need for targeted case management;
- d. The member is receiving targeted case management based on eligibility under an HCBS program but is no longer eligible for the program;
- e. The member or the member's representative requests termination;
- f. The member is unwilling or unable to accept further services; or
- g. The member or the member's representative fails to provide access to information necessary for the development of the service plan or for implementation of targeted case management.

90.3(2) The provider shall notify the member or the member's representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

441—90.4(249A) Case management services.

90.4(1) Covered services. The following shall be included in case management services provided to members, whether FFS members or MCO-enrolled members:

a. Assessment. Initial comprehensive assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The comprehensive assessments and reassessments shall address all of the applicant's and member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each population. Initial assessments must be face to face. Reassessments may be either face to face or telephonic dependent upon the assessment tool and population as designated in 441—Chapter 83. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the member.

b. Person-centered service plan. At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the comprehensive assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, representatives, and others as necessary to form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan.

(1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled.

(2) Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include:

1. The member or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.

2. The process is timely and occurs at times and locations of convenience to the member, the member's representative and family members, and others, as practicable.

3. Necessary information and support are provided to ensure that the member or the member's representative, or both, are central to the process and understand the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process.

5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs.

6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.

7. The planning process must provide meaningful access to members and their representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.

9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.

11. The member or the member's representative shall be central in determining what available HCBS are appropriate and will be used.

12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.

13. The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.

14. The planning process should not be constrained by any case manager's or representative's preconceived limits on the member's ability to make choices.

15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.

(3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall:

1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. Be prepared in person-first singular language and be understandable by the member or the member's representative, or both.

3. Note the strengths-based positive attributes of the member at the beginning of the plan.

4. Identify risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Document goals in the words of the member or the member's representative, or both, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality of life concepts important to the member.

6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.

7. Document the specific person or persons, provider agency and other entities providing services and supports.

8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.

9. Document non-paid supports and items needed to achieve the goals.
 10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's representative, or both, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.
 11. Identify each person and entity responsible for monitoring the plan's implementation.
 12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member.
 13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).
 14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen.
 15. Be distributed directly to all parties involved in the planning process.
- c. Referral and related activities.* The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.
- d. Monitoring and follow-up.* The case manager shall perform, as needed, monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:
- (1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;
 - (2) The member has declined services in the service plan;
 - (3) Communication among providers is occurring, as practicable, to ensure coordination of services;
 - (4) Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and
 - (5) There are changes in the needs or circumstances of the member. Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers.
- e. Contacts.* Case managers shall make contacts with the member, the member's representative, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:
- (1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly;
 - (2) The case manager shall have at least one contact per month with the member or the member's representative. This contact may be face to face or by telephone;
 - (3) Community-based case management contacts will be made in accordance with the Medicaid contract MED-16-019, or subsequent Medicaid managed care contracts with the department, in those instances where the contract specifies contacts different from this rule.
- 90.4(2) Exclusions.** For all case management services, fee-for-service payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist:
- a.* The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

- (1) Services under parole and probation programs;
- (2) Public guardianship programs;
- (3) Special education programs;
- (4) Child welfare and child protective services; or
- (5) Foster care programs.

c. The activities are components of the administration of foster care programs, including but not limited to the following:

- (1) Research gathering and completion of documentation required by the foster care program;
- (2) Assessing adoption placements;
- (3) Recruiting or interviewing potential foster care parents;
- (4) Serving legal papers;
- (5) Conducting home investigations;
- (6) Providing transportation related to the administration of foster care;
- (7) Administering foster care subsidies; or
- (8) Making placement arrangements.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

441—90.5(249A) Rights restrictions. Any effort to restrict the rights of a member to realize the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. The following requirements must be documented in the plan when a safety need has been identified that warrants a rights restriction:

1. The specific and individualized assessed safety need;
2. The positive interventions and supports used prior to any modifications or additions to the person-centered service plan regarding safety needs;
3. The less intrusive methods of meeting the safety needs that have been tried but were not successful;
4. A clear description of the rights restriction that is directly proportionate to the specific assessed safety need;
5. The regular collection and review of data to measure the ongoing effectiveness of the rights restriction;
6. The established time limits for periodic reviews to determine whether the rights restriction is still necessary or can be terminated;
7. The informed consent of the member to the proposed rights restriction; and
8. An assurance that the rights restriction itself will not cause undue harm to the member.

441—90.6(249A) Documentation and billing.

90.6(1) Documentation of contacts.

a. Documentation of case management services contacts shall include:

- (1) The name of the individual case manager;
- (2) The need for, and occurrences of, coordination with other case managers within the same agency or referral or transition to another case management agency; and
- (3) Other requirements as outlined in rule 441—79.3(249A) to support payment of services.

b. Targeted case management providers serving FFS members must also adhere to 441—subrule 24.4(4).

90.6(2) Rounding units of service for case management services. For all fee-for-service case management units of service, the following rounding process shall be used:

- a. Add together the minutes spent on all billable activities during a calendar day for a daily total;
- b. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day;
- c. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit; and
- d. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

90.6(3) Collateral contacts. For all fee-for-service case management units of service, the case manager may bill for documented contacts with other entities and individuals if the contacts are directly related to the member's needs and care, such as helping the member access services, identifying needs and supports to assist the member in obtaining services, providing other case managers with useful feedback, and alerting other case managers to changes in the member's needs.

90.6(4) Billable activities for case management services. Billable activities for case management services are limited to the following activities, and any activity included in this list must be billed if the activity has occurred.

- a. Face-to-face meeting with the member:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- b. Telephone conversation with the member:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- c. Collateral contacts on behalf of the member, including face-to-face, the telephone, and email contacts:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- d. Individual care plans and person-centered service plans:
 - (1) Creation; and
 - (2) Revision.
- e. Social histories:
 - (1) Creation; and
 - (2) Revision.
- f. Assessments and reassessments:
 - (1) Participation during the assessment if requested by the member; and
 - (2) Utilization of the assessment for creation of the person-centered service plan.

441—90.7(249A) Case management services provider requirements.

90.7(1) Reporting procedures for major incidents.

- a. When a major incident occurs or a staff member becomes aware of a major incident:
 - (1) The staff member shall notify the following persons of the incident by midnight of the next calendar day after the incident:
 1. The staff member's supervisor;
 2. The member or member's legal guardian; and
 3. The member's case manager. The case manager shall create an incident report if a provider has not submitted a report.
 - (2) By midnight of the next business day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known by the staff member about the incident to the member's managed care organization in the format required by the managed care organization. If the member is not enrolled with a managed care organization, or is receiving money

follows the person funding, the staff member shall report the information by direct data entry into the Iowa Medicaid portal access (IMPA) system. The case manager is responsible for reporting the incident if the provider of service has not already reported the incident.

(3) The following information shall be reported:

1. The name of the member involved;
2. The date, time, and location where the incident occurred;
3. A description of the incident;
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other Medicaid-eligible members or non-Medicaid-eligible persons who were present must be maintained by the use of initials or other means;

5. The action taken to manage or respond to the incident;

6. The resolution of or follow-up to the incident; and

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) When complete information about the incident is not available at the time of the initial report, the case management services provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up.

(5) The case management services provider shall maintain the completed report in a centralized file with a notation in the member's file.

(6) The case management services provider shall track incident data and analyze trends to assess the health and safety of members served and to determine whether changes need to be made for service implementation or whether staff training is needed to reduce the number or severity of incidents.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation to ensure that the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the service plan in order to ensure the continued health, safety, and welfare of the member. Documentation must be made in the person-centered service plan of this review and follow-up activities.

90.7(2) Reporting procedures for minor incidents. Minor incidents may be reported in any format designated by the case management services provider. When a minor incident occurs, or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

90.7(3) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise or a Medicaid managed care organization, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

- a. Postpayment review of case management services;
- b. Review of incident reports;
- c. Review of reports of abuse or neglect; and
- d. Technical assistance in determining the need for service.

These rules are intended to implement Iowa Code section 249A.4.



Administrative Rule Fiscal Impact Statement

Date: May 14, 2019

Agency: Human Services
IAC citation: 441 IAC Chapter 90
Agency contact: Leann Howland

Summary of the rule:

Medicaid program case management services, including use of Core Standardized Assessments or other assessment tools, incident reporting requirements, appeals to the Department, rounding rules and billable case management service activities, person centered service planning, and parameters of Targeted Case Management.

Fill in this box if the impact meets these criteria:

No fiscal impact to the state.

- Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
 Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

There is no expected fiscal impact as most of the items included in this revision are either already included in a State Plan Amendment (IHH Care Coordination), are part of the Balanced Incentive Payment (BIP for Core Standardized Assessment), are contained in the MCO contract, or have been in practice without rule. It also does not change unit calculations or rate methodologies.

Fill in the form below if the impact does not fit the criteria above:

- Fiscal impact of \$100,000 annually or \$500,000 over 5 years.

Assumptions:

Describe how estimates were derived:

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 2020)	Year 2 (FY 2021)
Revenue by each source:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL REVENUE	_____	_____
Expenditures:		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
TOTAL EXPENDITURES	_____	_____
NET IMPACT	_____	_____

c>J This rule is required by state law or federal mandate.

Please identify the state or federal law:

Identify provided change fiscal persons:

Iowa Code sec. 249A.4

2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142(20)

42 C.F.R. §§ 441.301(b)(1)(i), (c)(1)-(3) and 441.725

Iowa 2013 Senate File 446, section 12(19)(a)(8) and section 142(18)(a)

D Funding has been provided for the rule change.

Please identify the amount provided and the funding source:

c>J Funding has not been provided for the rule.

Please explain how the agency will pay for the rule change:

There is no expected fiscal impact.

Fiscal impact to persons affected by the rule:

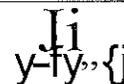
There is no expected fiscal impact.

Fiscal impact to counties or other local governments (required by Iowa Code 258.6):

No fiscal impact.

Agency representative preparing estimate: Jason Buis

Telephone number: _____ 515-281-5764





Iowa Department of Human Services
Information on Proposed Rules

Name of Program Specialist

Telephone Number

Email Address

Leann Howland

515-256-4642

lhowlan@dhs.state.ia.us

1. Give a brief purpose and summary of the rulemaking:

- Amends the name of the Chapter from 'Targeted Case Management' to "Case Management Services". Clarifies that the term "case management services" will refer to activities and supports provided through Case Management, Targeted Case Management, Community Based Case Management, and Integrated Health Home (IHH) Care Coordination.
- These changes define the case management services activities received by various populations under the Medicaid program.
- Consolidates all references to Targeted Case Management to flow consecutively rather than being dispersed throughout the chapter.
- Revises IAC to include definition and references to Core Standardized Assessments (CSA) as required under the Balancing Incentive Payment Program (SIPP). The SIPP was created pursuant to section 10202 of the federal Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and by 2013 Iowa Senate File 446, section 142(20), including provision of "core standardized assessment instruments."
- Adds a section to outline and require billable activities for fee for service members.
- Adds a section to outline and require 15-minute unit rounding rules for fee for service members.
- Adds a requirement for provider internal reporting of minor incidents.
- Adds the person-centered service planning definition and requirements as required by the Code of Federal Regulations at 42 C.F.R. §§ 441.301(b)(1)(i), (c)(1)-(3) and 441.725
- Updates chapter 90 rules citations in other IAC chapters that are affected by this rules package.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

- Iowa Code sec. 249A.4
- 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142(20)
- 42 C.F.R §§ 441.301(b)(1)(i), (c)(1)-(3) and 441.725
- Iowa 2013 Senate File 446, section 12(19)(a)(8) and section 142(18)(a)

3. Describe who this rulemaking will positively or adversely impact.

- IHH: There will be no effect on providers or members in regards to the IHH references as these provisions codify policies already followed by IHH providers pursuant to 441-IAC 77.47 and 78.53.
- CSA and SIPP: CSA was implemented in 2016 and is in rule in Chapter 83.
- Billable activities: will cause case management service providers to revise their internal processes to adhere to this rule. The activities list was announced in IL 1394 but had not yet been put into rule.
- Rounding rules: case management service providers already effectuated this change beginning 7/1/13.
- Minor incidents: All 1915(c) and 1915(i) members are subject to internal minor incident reports. This requirement has already been implemented by other HCBS providers as included in IAC Chapter 77. This revision is putting into rule what has already been common practice for case managers.
- Case management service providers are required to actively engage the members and those the members choose in developing a comprehensive person-center service plan or treatment plan. The member will benefit because they will be driving the person-centered planning process. The individual identifies planning goals to achieve those personal outcomes in collaboration with those that the

individual has identified including medical, clinical, vocational, direct service and other professional staff.

4. Does this rule contain a waiver provision? If not, why?

These amendments do not contain waiver provisions because Medicaid has determined that the same rules should be applicable to all members and providers who are eligible and because Individual members or providers may request a waiver under the Department's general rule on exceptions at IAC 441--1.8.

5. What are the likely areas of public comment?

- Comments may be received for a variety of reasons, but most of the items included in this revision are either already included in a State Plan Amendment (IHH Care Coordination), are part of the Balanced Incentive Payment (BIP for Core Standardized Assessment), are contained in the MCO contract, or have been in practice without rule.
- The case management service entities will comment on the Case Management Billable Activities list. IME issued IL 1394 on June 6, 2014 to announce upcoming rules changes.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

- No, these changes should not cause any impact on jobs or employment opportunities.

Iowa Medicaid Enterprise



Managed Care Organization Report: SFY 2019, Quarter 4 (April-June) Performance Data

Published October 9, 2019



CONTENTS

Executive Summary	2
Plan Enrollment By Age	4
Plan Enrollment by MCO.....	5
Plan Disenrollment by MCO.....	5
All MCO Long Term Services and Supports (LTSS) Enrollment	6
All MCO Home and Community-Based Service Waiver Enrollment.....	6
Care Coordination and Case Management	7
Consumer Protections and Supports	12
MCO Program Management.....	15
MCO Financials.....	35
Program Integrity.....	38
Health Care Outcomes.....	39
Appendix: Glossary.....	43

Legislative Requirements:

This report is based on requirements of 2016 Iowa Acts Section 1139. The legislature grouped these reports into three main categories:

- Consumer Protection
- Outcome Achievement
- Program Integrity

The Department grouped the managed care reported data in this publication as closely as possible to House File 2460 categories but has made some alterations to ease content flow and data comparison. This publication content will flow in the following way:

- Eligibility and demographic information associated with members assigned to managed care
- Care coordination related to specific population groupings (General, Special Needs, Behavioral Health, and Elderly)
- Consumer protections and support information
- Managed care organization program information related to operations
- Network access and continuity of providers
- Financial reporting
- Program integrity actions and recoveries
- Health care outcomes for Medicaid members
- Appendices with supporting information

This report is based on Quarter 4 of State Fiscal Year (SFY) 2019 and includes the information for the Iowa Medicaid Managed Care Organizations (MCO):

- Amerigroup Iowa, Inc. (Amerigroup, AGP)
- UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare, UHC)

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported annually. This will include measures associated with HEDIS^{®1} CAHPS², and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state has with the Centers for Medicare and Medicaid Services (CMS).
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However,

¹ The Healthcare Effectiveness Data and Information Set (HEDIS[®]) is a standardized, nationally-accepted set of performance measures that assess health plan performance and quality.

² The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized, nationally-accepted survey that assesses health plan member satisfaction.

based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

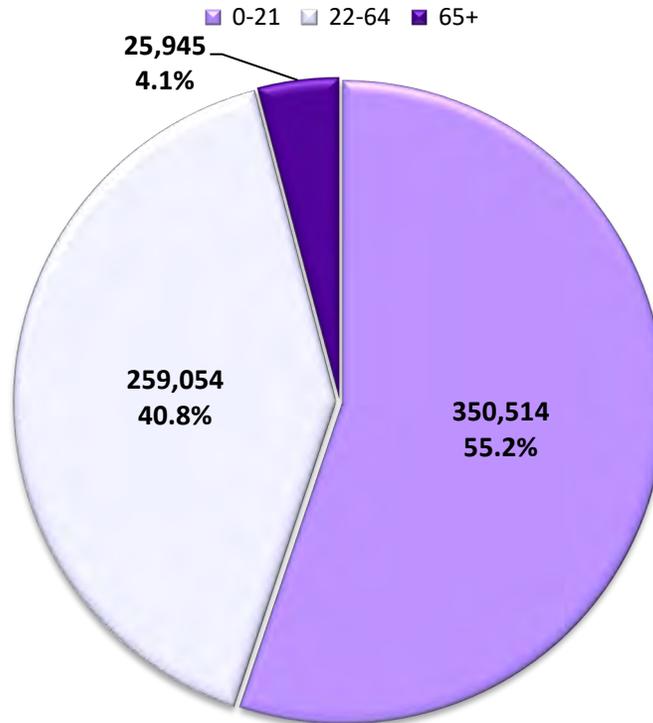
- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available Fee-for-Service historical baselines, encounter data, and by reviewing the source data provided by the MCOs.

More information on the move to managed care is available at <http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>.

Providers and members can find more information on the IA Health Link program at <http://dhs.iowa.gov/iahealthlink>.

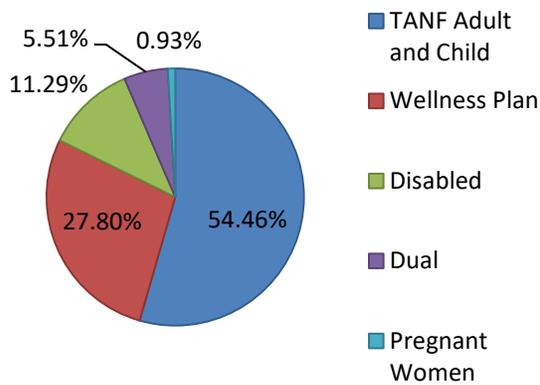
PLAN ENROLLMENT BY AGE

Managed Care Enrollment by Age Total MCO Enrollment = 635,513*

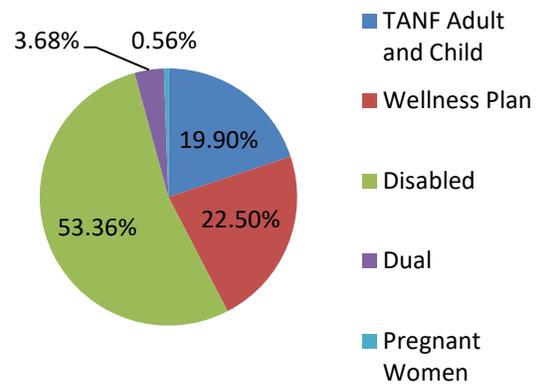


*June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes Hawki enrollees. 56,074 members remain in Fee-for-Service (FFS).

Capitated Enrollment

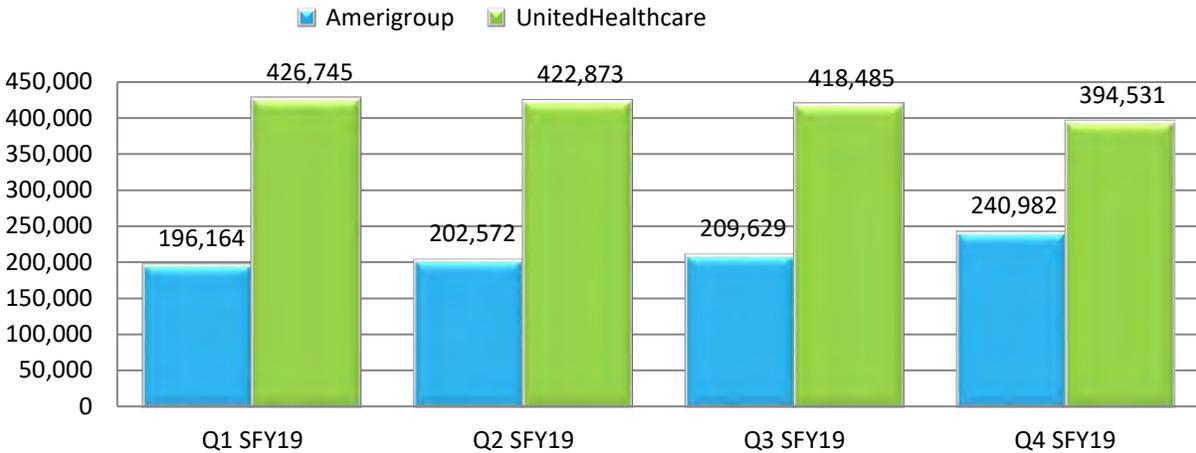


Capitation Expenditures



PLAN ENROLLMENT BY MCO

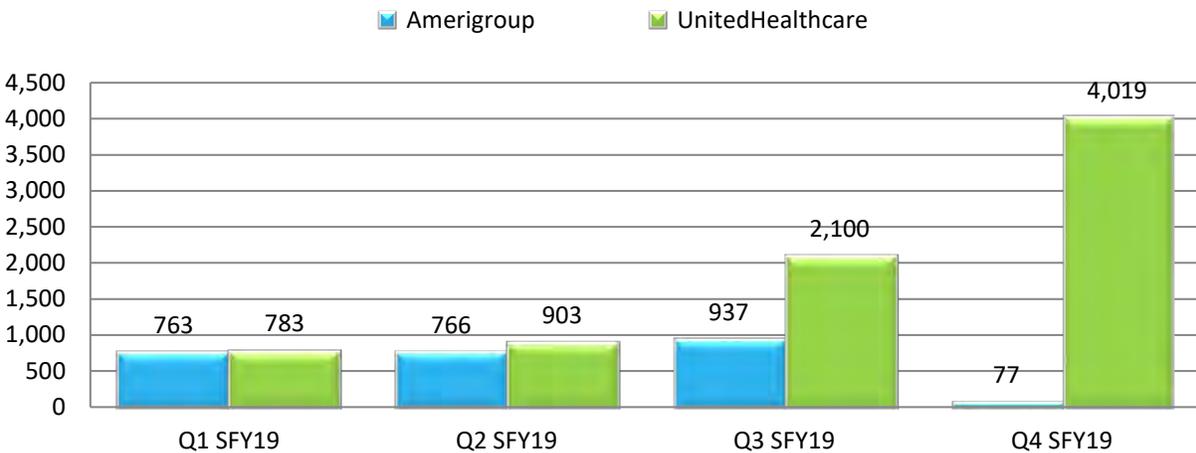
Total Plan Enrollment by MCO*



* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

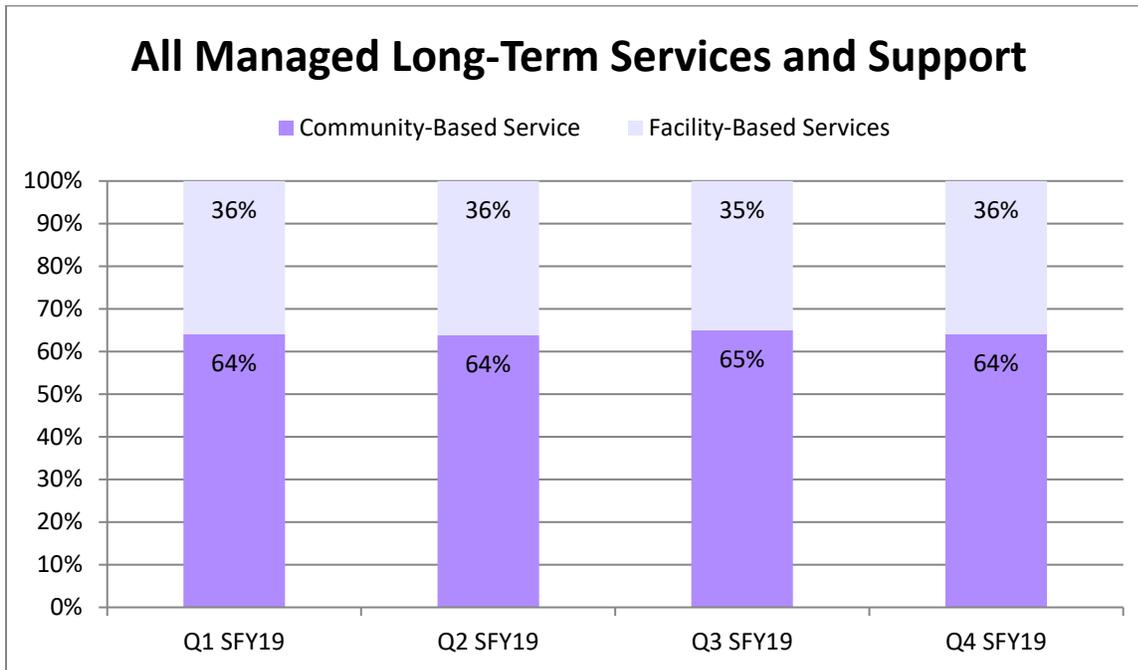
PLAN DISENROLLMENT BY MCO

Active Member Disenrollment by MCO*



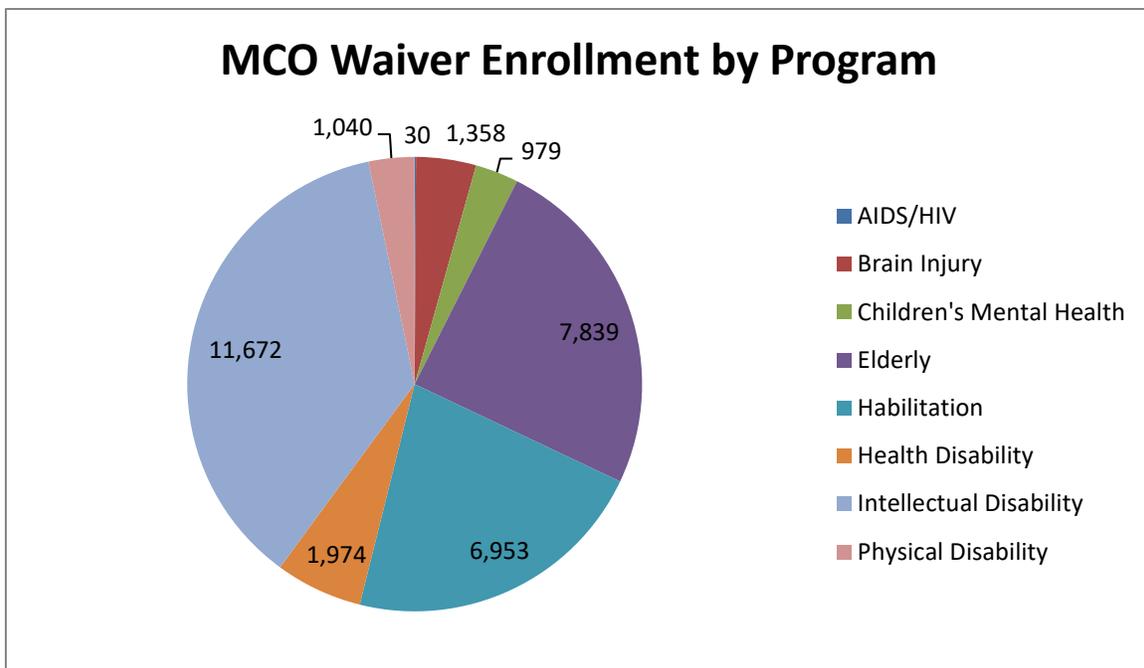
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT



Information on individual waiver enrollment and waitlists can be found at the dedicated webpage: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers>.

ALL MCO HOME AND COMMUNITY-BASED SERVICE WAIVER ENROLLMENT



CARE COORDINATION AND CASE MANAGEMENT

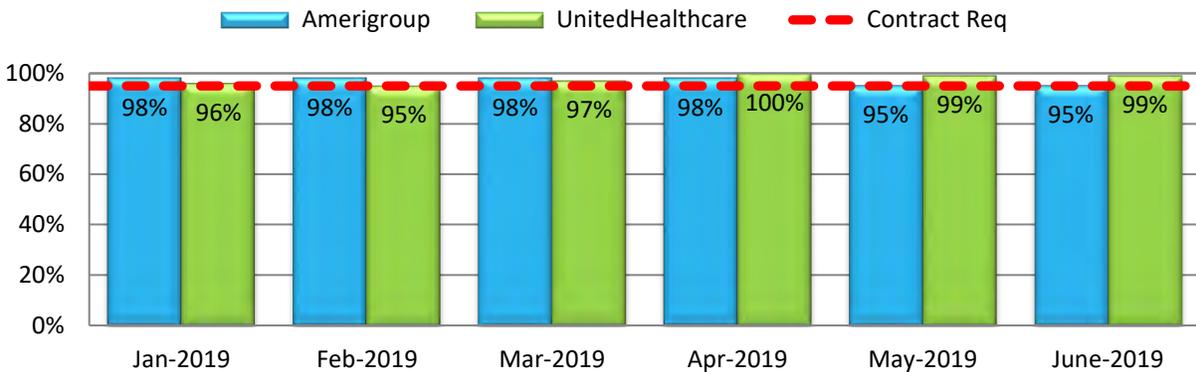
Average Number of Contacts		
Data Reported as of June 30, 2019	Amerigroup	UnitedHealthcare
Average Number of Care Coordinator Contacts per Member per Month	2.1	0.4
Average Number of Community-Based Case Manager Contacts per Member per Month	1.3	1.1

Member to Coordinator Ratios		
Data Reported as of June 30, 2019	Amerigroup	UnitedHealthcare
Ratio of Members to Care Coordinators	9	130
Ratio of HCBS Members to Community-Based Case Managers	64	95

Level of Care

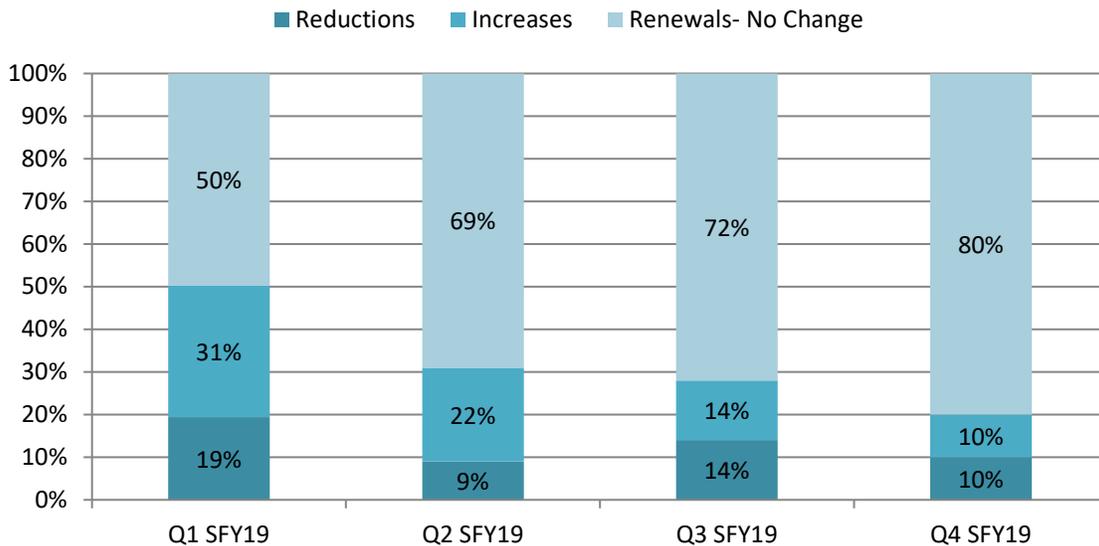
Level of care (LOC) and functional need assessments must be updated annually or as a member's needs change.

Percentage of LOC Reassessments Completed Timely

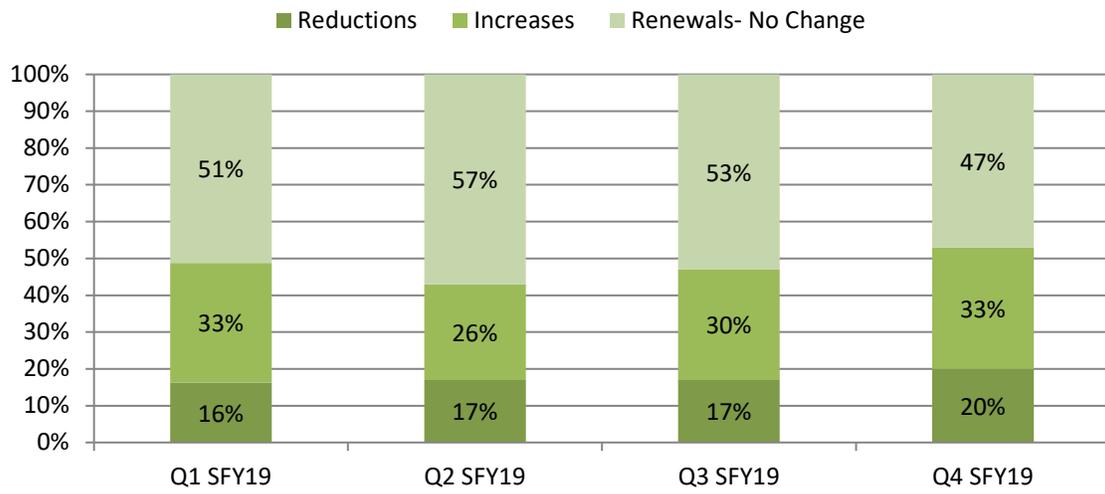


Service Plan Revision Outcomes reports how service plan authorizations are changed from year to year for members receiving Home and Community Based Services (HCBS). These are new measures for SFY 2019.

Amerigroup Service Plan Revision Outcomes



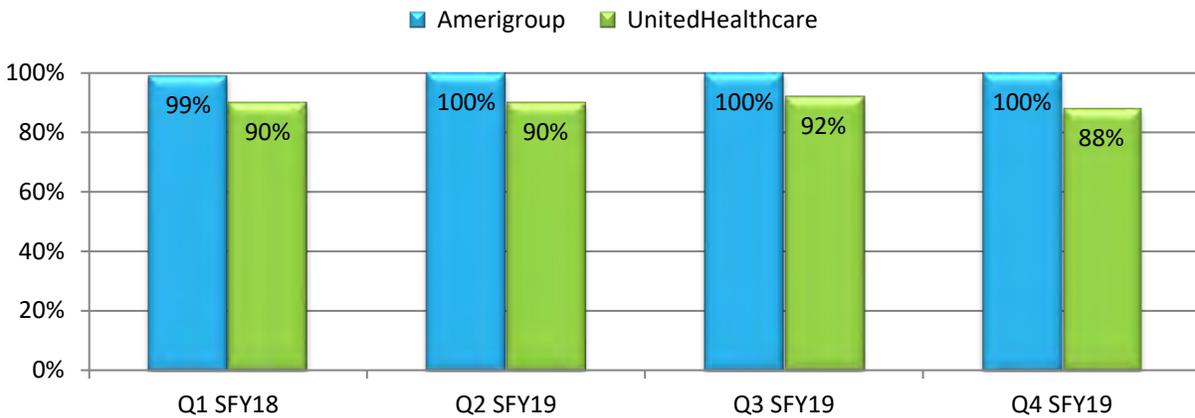
UnitedHealthcare Service Plan Revision Outcomes



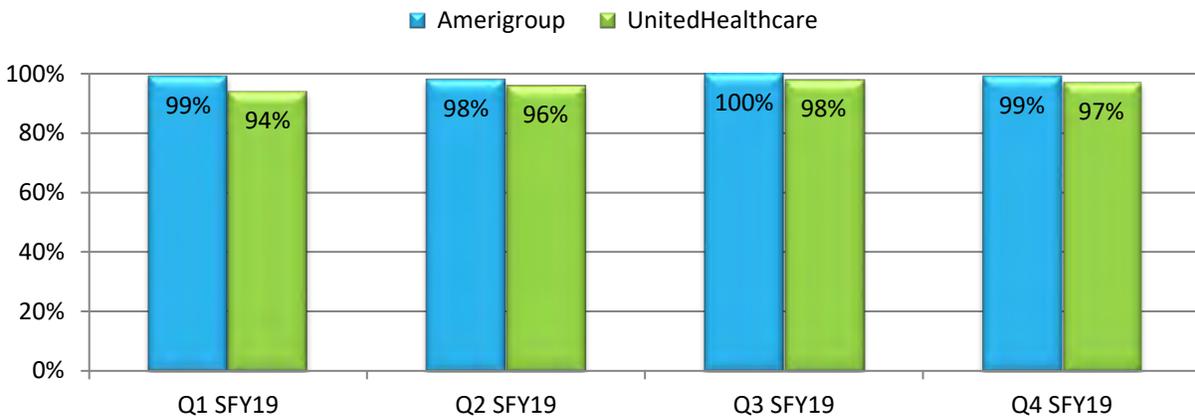
Iowa Participant Experience Survey Reporting

The data below reflect the results of Iowa Participant Experience Survey (IPES) activities and results. IPES results are one component of the Iowa Department of Human Services Home and Community Based Services quality strategy. Surveys are conducted to achieve a statistically significant representative sample by waiver with a 95% confidence level and a 5% error rate. Percentages reflect the number of survey responses in the quarter from all applicable waivers indicating “yes”. Other valid survey responses include “no,” “I don’t know,” “I don’t remember,” and “No/Unclear response.”

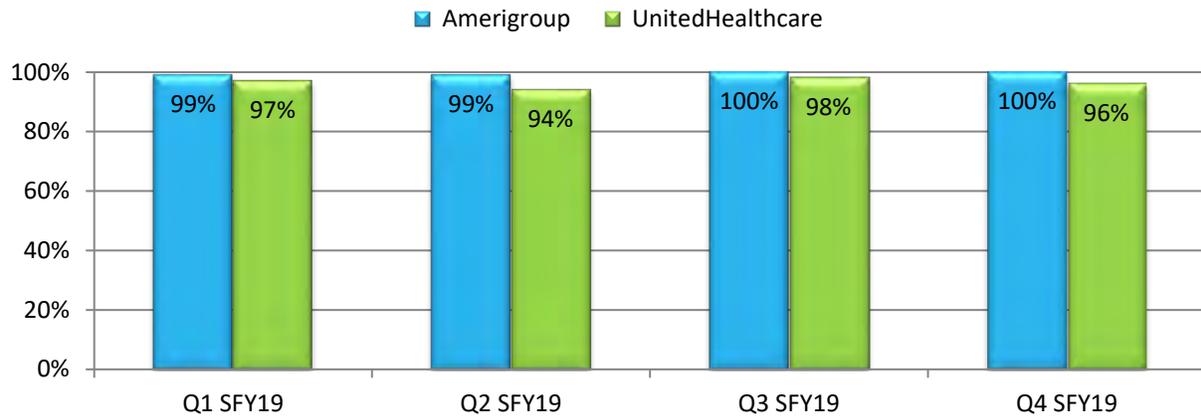
Members Reporting They Were Part of Service Planning



Members Reporting They Feel Safe Where They Live



Members Reporting Their Services Make Their Lives Better



MCO Member Grievances and Appeals

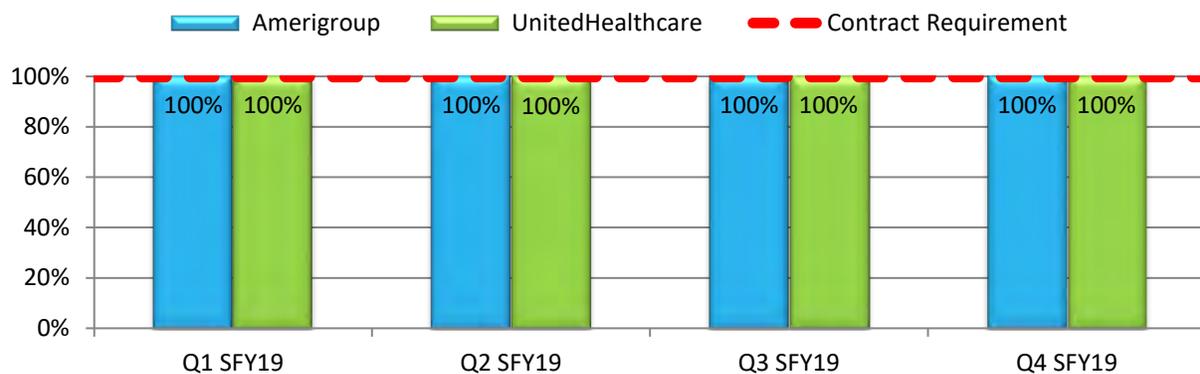
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the MCO.

Grievance: A written or verbal expression of dissatisfaction.

Appeal: A request for a review of an MCO's denial, reduction, suspension, termination or delay of services.

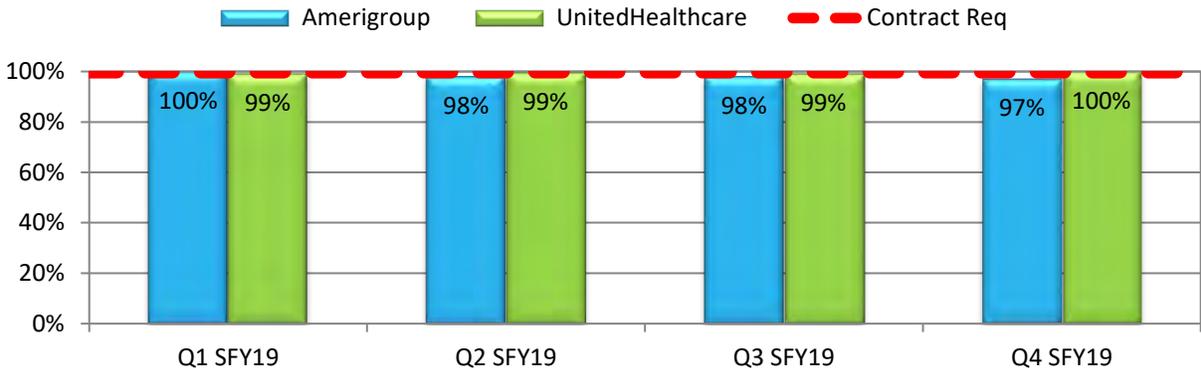
Resolved: The appeal or grievance has been through the process and a disposition has been communicated to the member and member representative.

Percentage of Grievances Resolved within 30 Calendar Days of Receipt



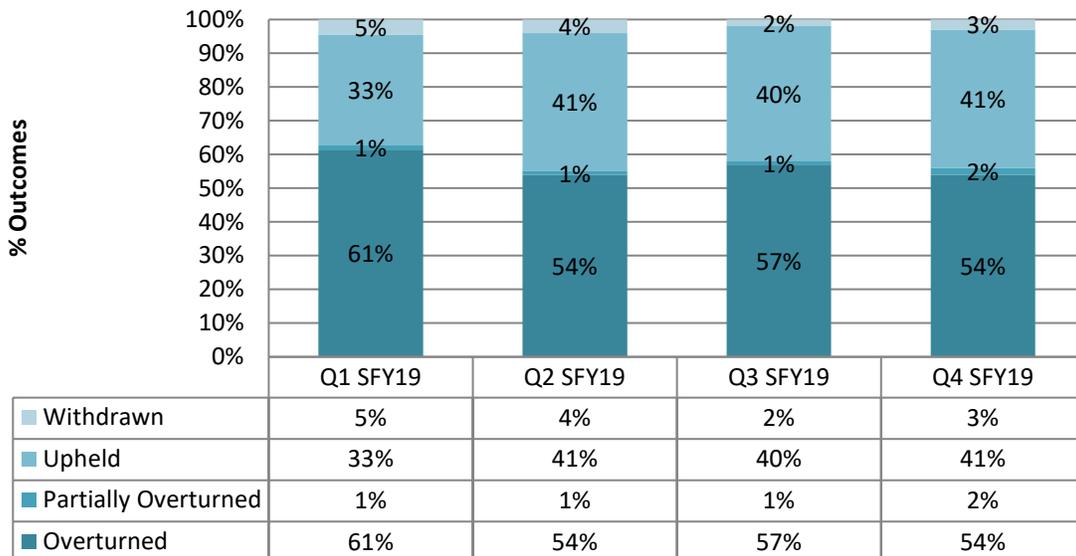
Supporting Data				
	Amerigroup		UnitedHealthcare	
Metric	Count	% Pop	Count	% Pop
Grievances Received in Q1 SFY19	228	0.10%	471	0.10%
Grievances Received in Q2 SFY19	280	0.13%	474	0.10%
Grievances Received in Q3 SFY19	314	0.14%	307	0.07%
Grievances Received in Q4 SFY19	248	0.09%	205	0.05%

Percentage of Appeals Resolved within 30 Calendar Days of Receipt

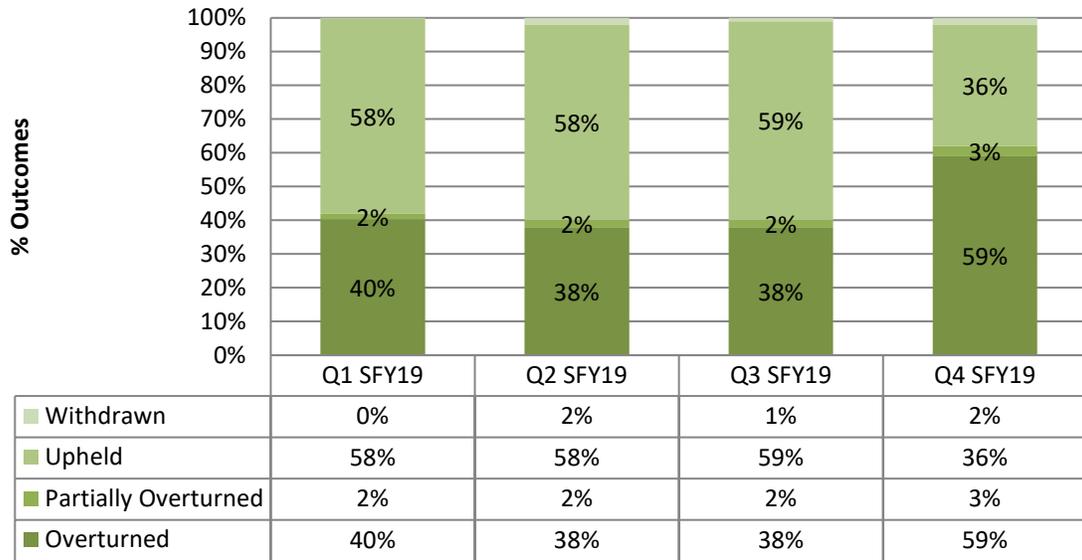


Supporting Data				
Metric	Amerigroup		UnitedHealthcare	
	Count	% Claims	Count	% Claims
Appeals Received in Q1 SFY19	285	0.01%	385	0.01%
Appeals Received in Q2 SFY18	239	0.01%	317	0.01%
Appeals Received in Q3 SFY19	233	0.01%	252	0.01%
Appeals Received in Q4 SFY19	211	0.01%	225	0.01%

Amerigroup Appeal Outcomes

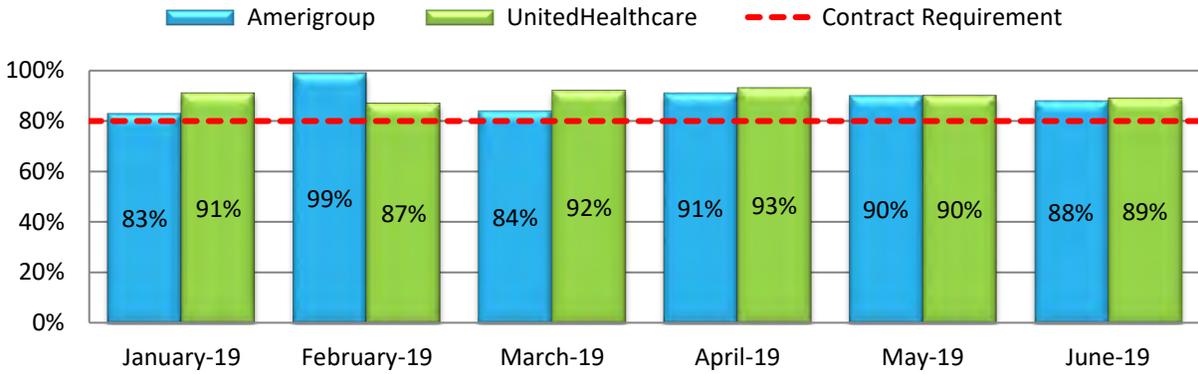


UnitedHealthcare Appeal Outcomes

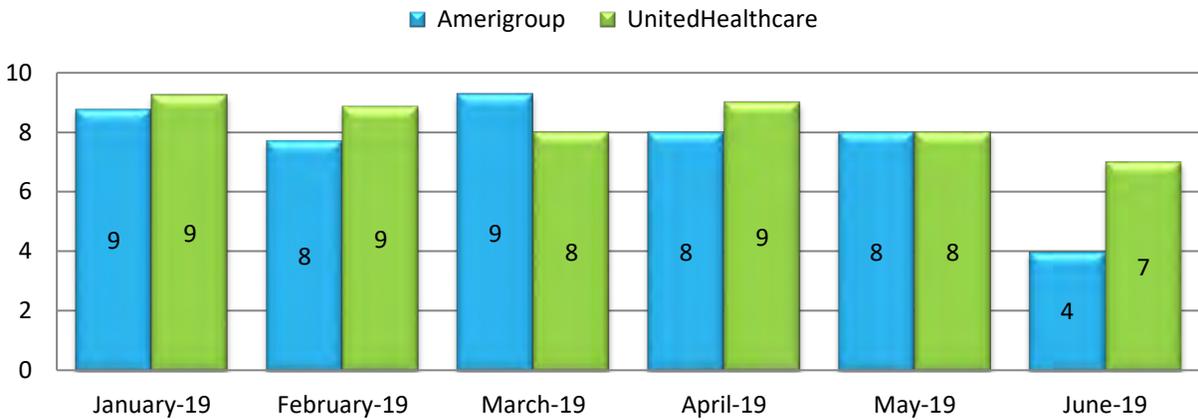


Member Helpline

Service Level: Percentage of Member Helpline Calls Answered Timely

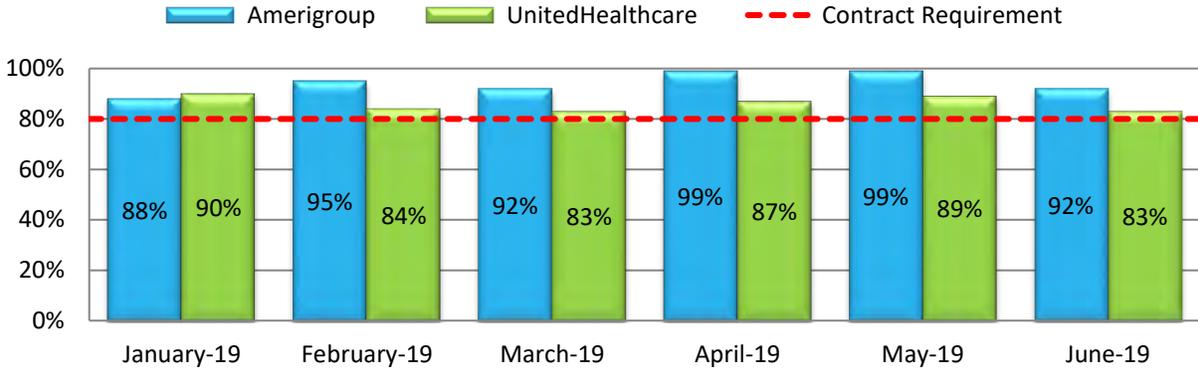


Secret Shopper: Member Helpline Average Monthly Score

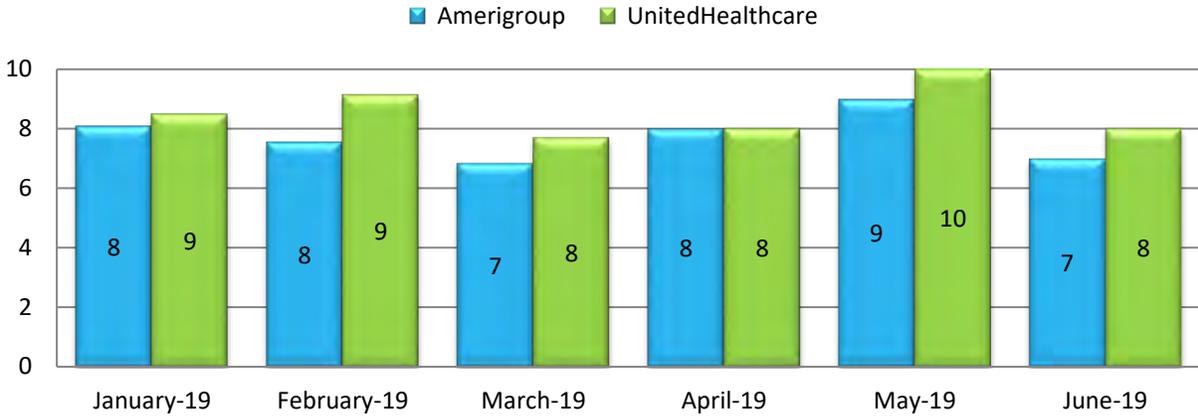


Provider Helpline

Service Level: Percentage of Provider Helpline Calls Answered Timely

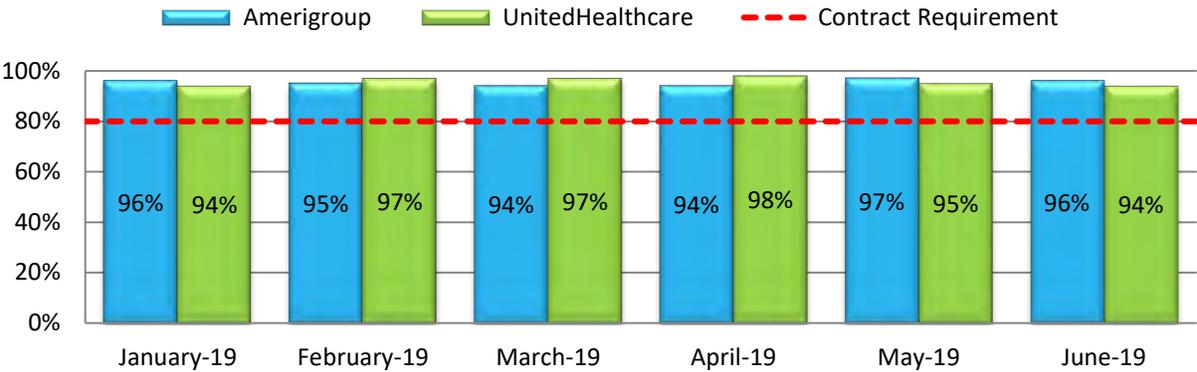


Secret Shopper : Provider Helpline Average Monthly Score



Pharmacy Services Helpline

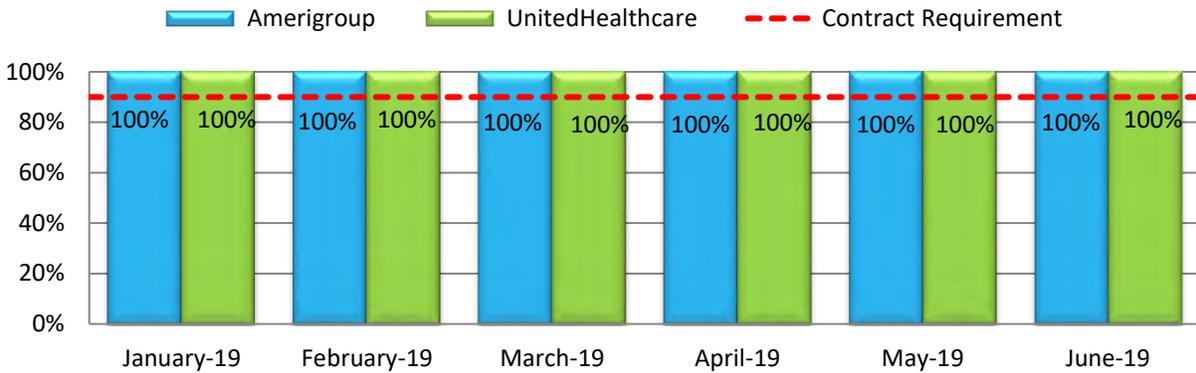
Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely



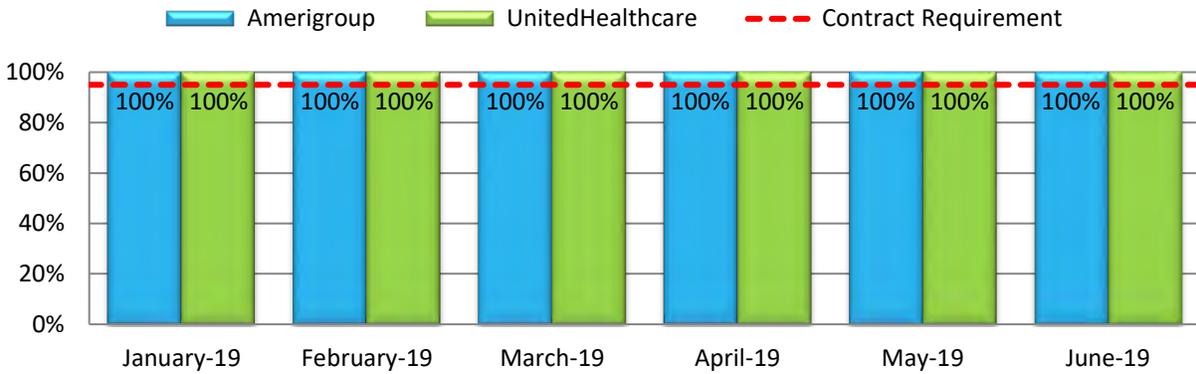
Non-Pharmacy Claims Payment

Non-pharmacy claims processing data is for the entire quarter.

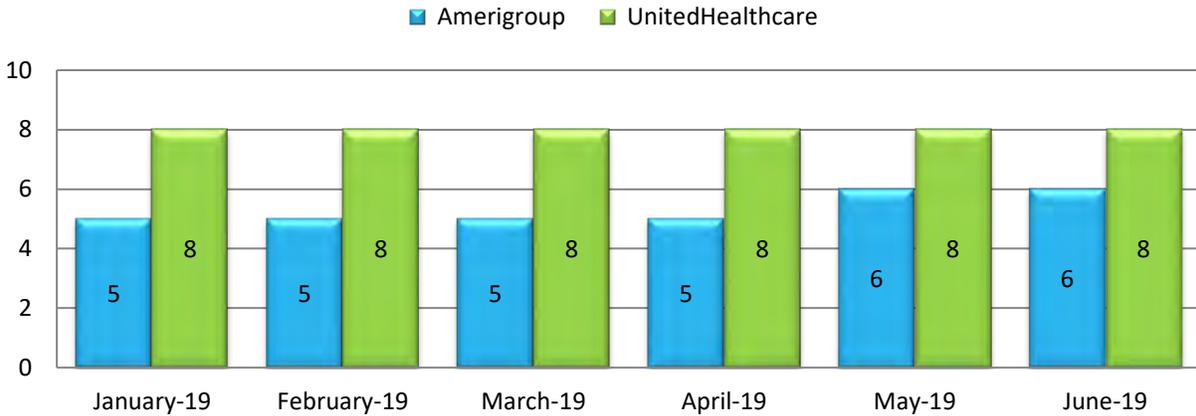
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 30 Calendar Days



Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 45 Calendar Days

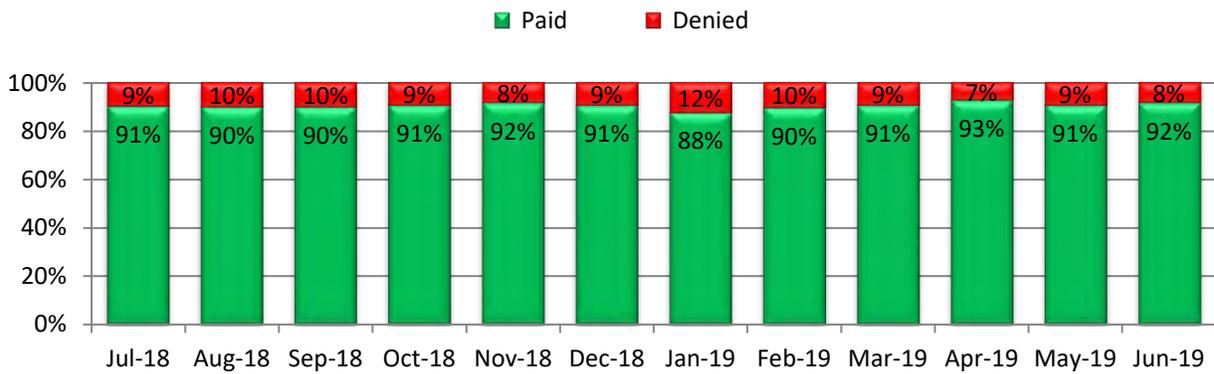


Average Days for Non-Pharmacy Claims Payment



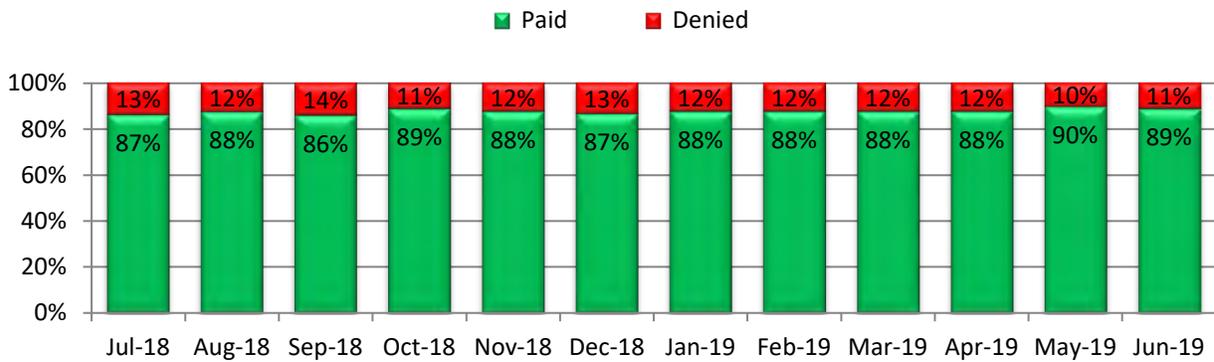
Amerigroup Non-Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Non-Pharmacy Claims Status

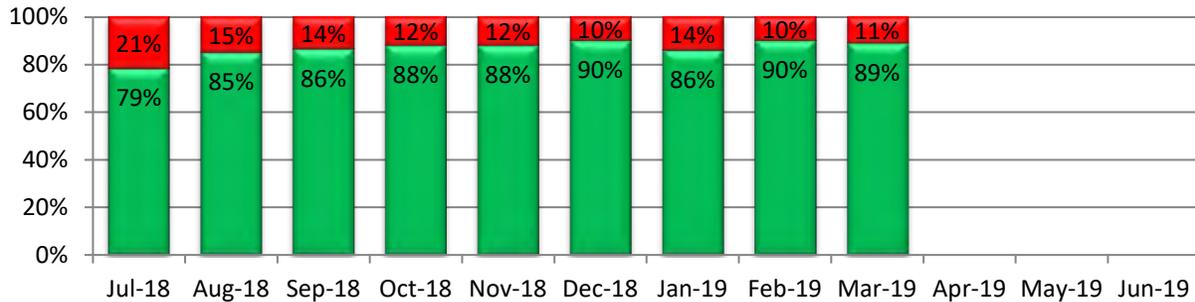
**As of the end of the reporting period



Amerigroup Suspended Non-Pharmacy Claims Payment Rates

**As of the end of the reporting period

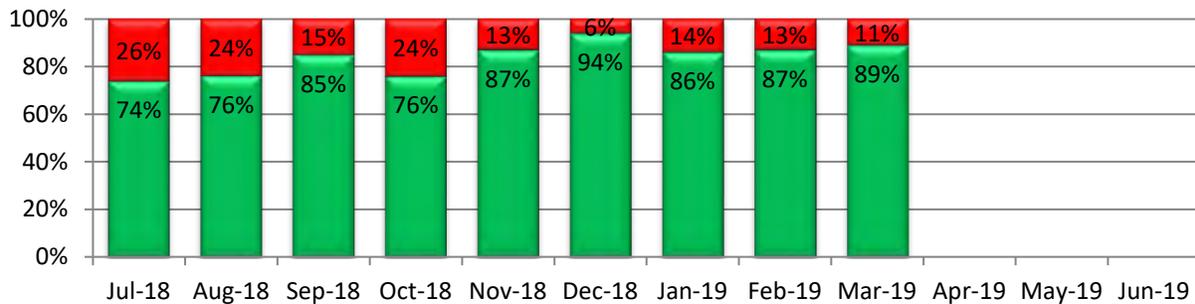
■ Paid ■ Denied



UnitedHealthcare Suspended Non-Pharmacy Claims Payment Rates

**As of the end of the reporting period

■ Paid ■ Denied



Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period

CARC and RARC are defined below table

#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
1.	18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	30%	CARC-18 Exact duplicate claim/service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim	15%
2.	27-Expenses incurred after coverage terminated	15%	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary	13%

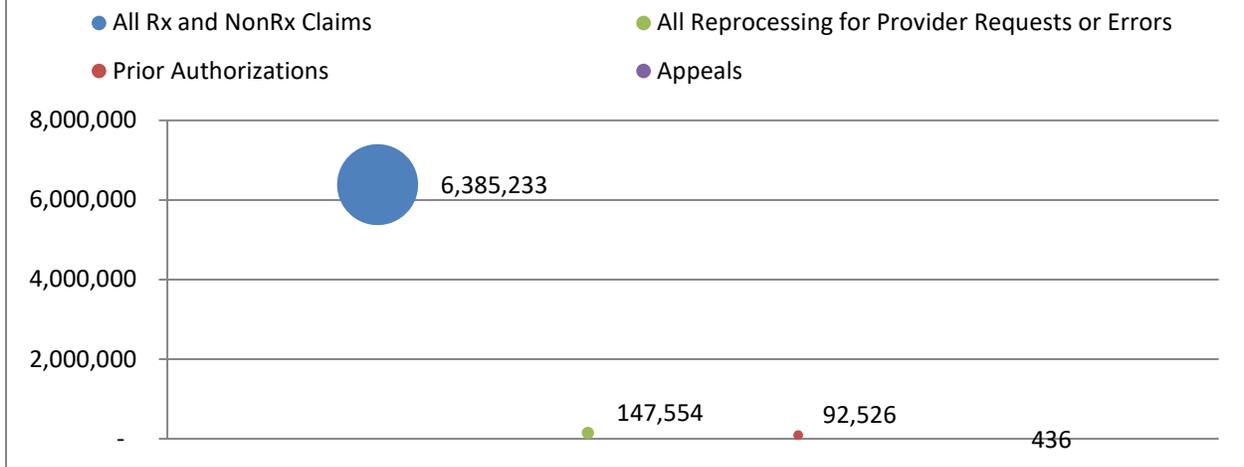
Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
			payer. The information was either not reported or was illegible.	
3.	252-An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT) N479-Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)	9%	CARC-208 National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.	12%
4.	256-Service not payable per managed care contract	6%	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service	11%
5.	45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges	6%	CARC-29 The time limit for filing has expired.	6%
6.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	5%	CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.	6%
7.	29-The time limit for filing has expired	5%	CARC-256 Service not payable per managed care contract. RARC-N448 This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	4%
8.	197- Precertification/authorization/notification absent	5%	CARC-97 The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. RARC-M15 Separately billed services/tests have been bundled as	3%

Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
			they are considered components of the same procedure. Separate payment is not allowed.	
9.	<p>97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present</p> <p>N432-Alert: Adjustment based on a Recovery Audit</p>	3%	CARC-23 The impact of prior payer(s) adjudication including payments and/or adjustments.	2%
10.	<p>16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present</p> <p>MA130-Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information</p>	1%	CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.	2%

Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. <http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/>

Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. <http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/>

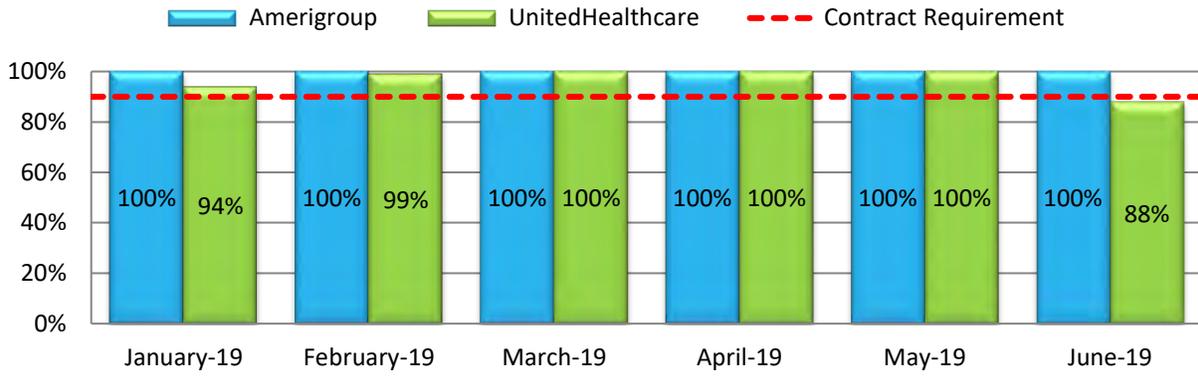
Quarterly Scope of Claims, Reprocessing, PAs, and Appeals



Quarterly Volume of Claims, Reprocessing, PAs, and Appeals depict at scale the universe of actions that may be associated with paid or denied claims. Some claims require prior authorizations for services while other claims may be reprocessed due to provider requests or errors, and still others may be appealed by members. These numbers with the illustration provide context on the volume of these actions in the combined managed care universe of claims.

Supporting Data		
All Rx and NonRx Claims	6,385,233	% of Claims Universe
All Rx and NonRx Reprocessing for Provider Requests or Errors	147,554	2.31%
All Rx and NonRx Prior Authorizations	92,526	1.45%
Appeals	436	0.01%

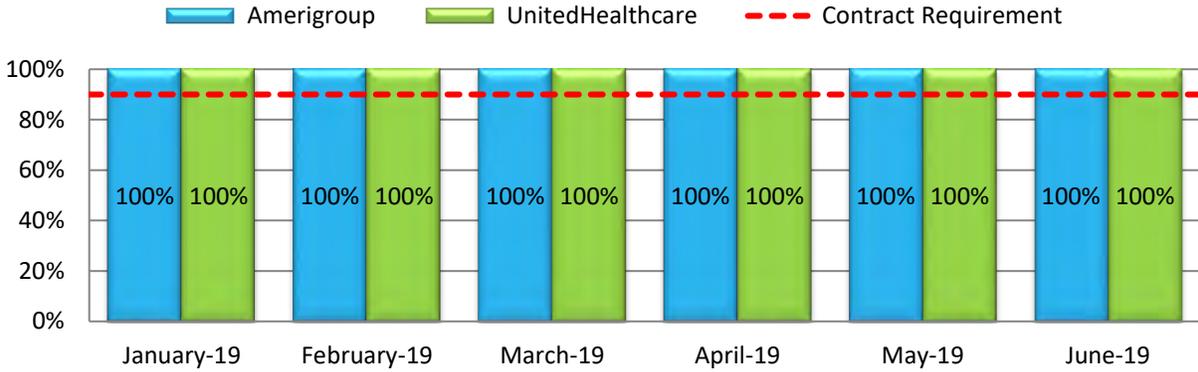
Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification



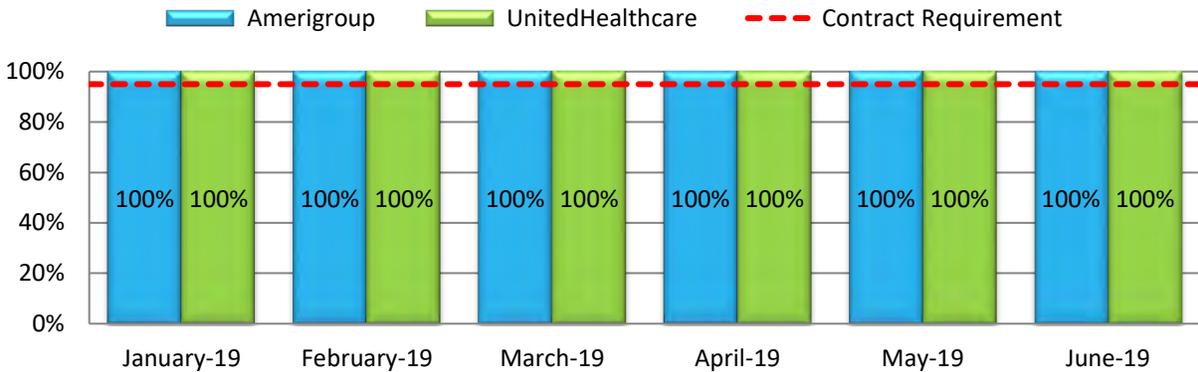
Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.

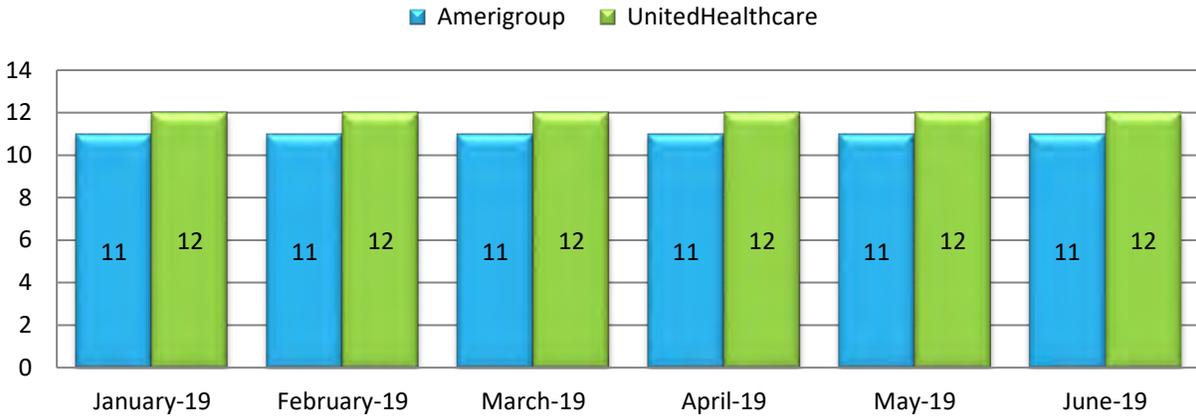
Percentage of Clean Pharmacy Claims Paid or Denied Within 30 Calendar Days



Percentage of Clean Pharmacy Claims Paid or Denied Within 45 Calendar Days

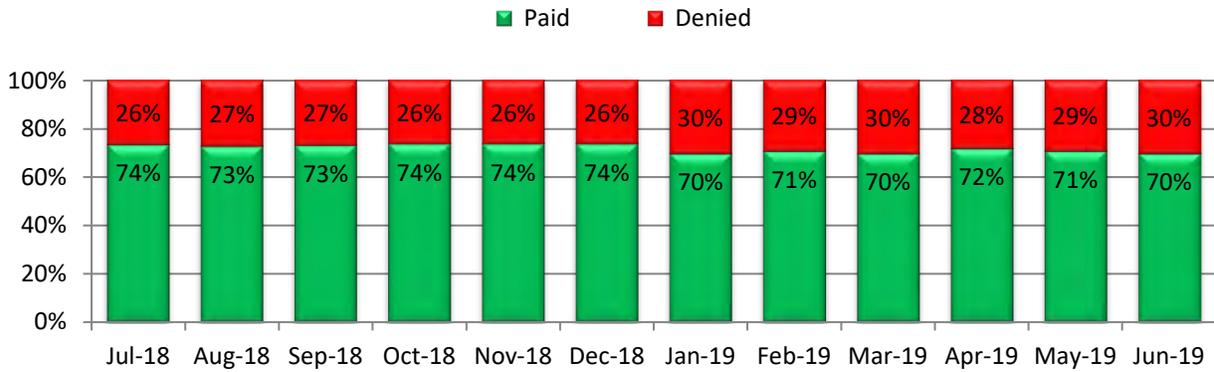


Average Days for Pharmacy Claims Payment



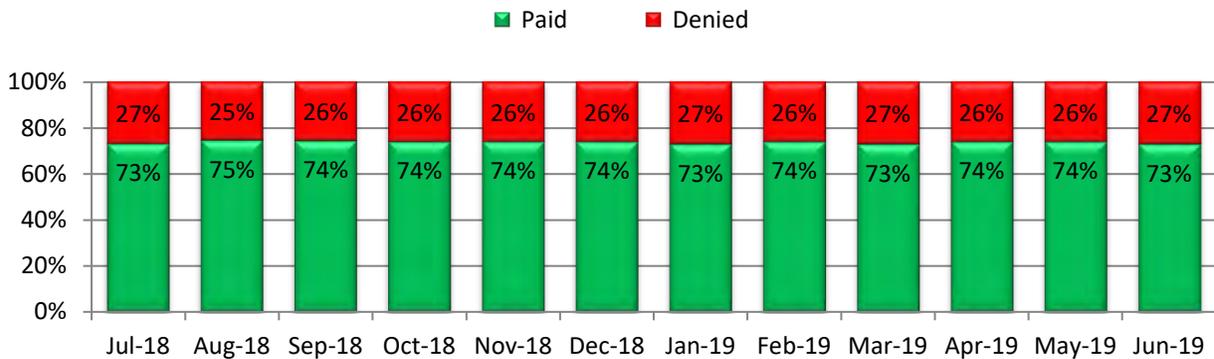
Amerigroup Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period



Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
1.	Refill Too Soon	31%	Refill Too Soon	40%
2.	Product Not On Formulary	12%	Prior Authorization Reqrd	15%
3.	Product/Service Not Covered – Plan/Benefit Exclusion	9%	Prod/Service Not Covered	13%
4.	Days' Supply Exceeds Plan Limitation	9%	Filled After Coverage Trm	10%
5.	Plan Limitations Exceeded	7%	Plan Limitations Exceeded	7%
6.	Submit Bill To Other Processor Or Primary Payer	5%	Sbmt bill to other procsr	5%
7.	Prior Authorization Required	4%	M/I Other Coverage Code	2%
8.	DUR Reject Error	4%	DUR Reject Error	2%
9.	Scheduled Downtime	3%	Non-Matched Pharmacy Nbr	1%
10.	This Medicaid Patient Is Medicare Eligible	2%	Prescriber is Not Covered	1%

Utilization of Value Added Services Reported Count of Members	
MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.	
Q4 SFY19 Data	UnitedHealthcare
Baby Blocks	2,985
School/Camp/Sports Physicals	48
Non Emergent Transportation	932
Weight Watchers	105

Utilization of Value Added Services Reported Count of Members

MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

Q4 SFY19 Data	Amerigroup
Weight Watchers	169
Exercise Kit	45
Dental Hygiene Kit	35
Personal Bag for Belongings with Comfort Item	9
SafeLink Mobile Phone	83
Healthy Families Program	25
Community Resource Link	625
Live Health Online	25
Healthy Rewards	2,394
Taking Care of Baby and Me	4,671
Boys & Girls Club	67
Personal Care Attendant	7
Home Delivered Meals	10
Post-Discharge Stabilization Kit	1

The Department is in the process of reviewing how this information is shared on its website and will provide an updated link in the next report.

Provider Network Access

There are two major methods used to determine adequacy of network in the contract between the Department and the MCOs:

- Member and provider ratios by provider type and by region
- Geographic access by time and distance

As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the Department when the MCO clearly demonstrates that:

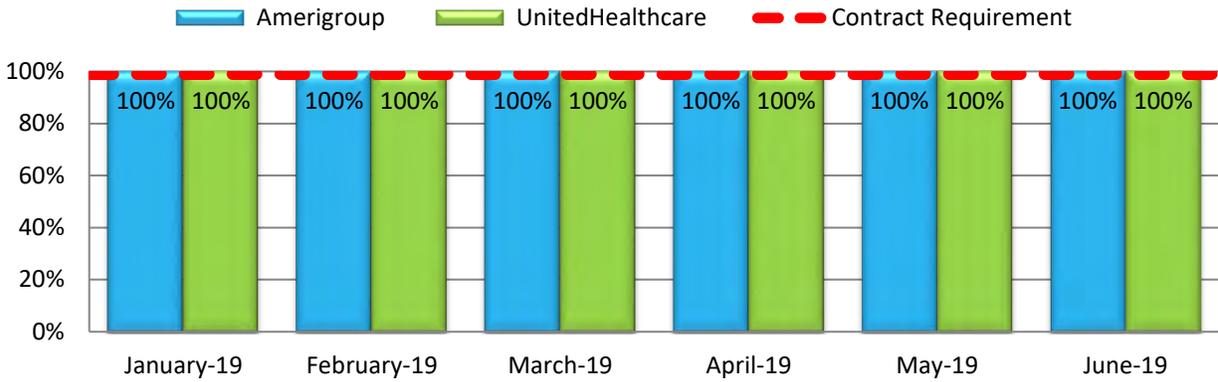
- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area.

Links to time and distance reports can be found at:

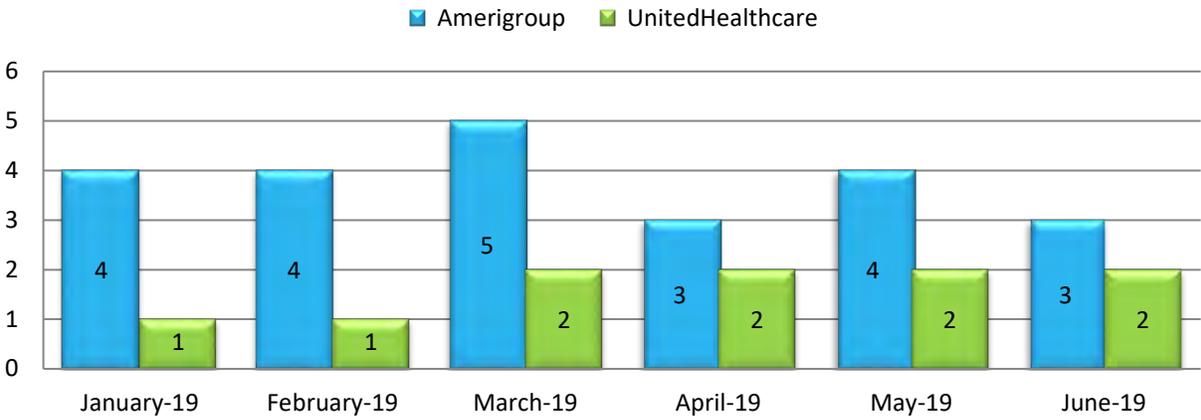
<https://dhs.iowa.gov/ime/about/performance-data-GeoAccess>.

Non-Pharmacy Prior Authorization

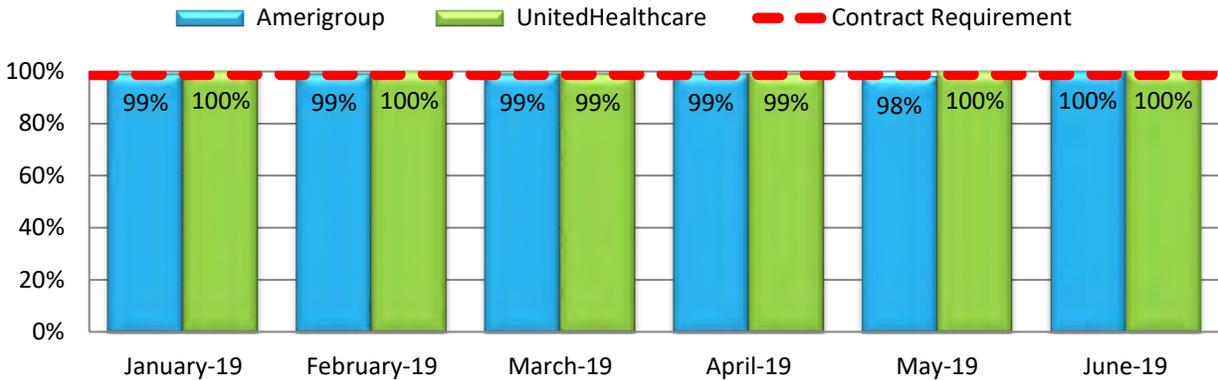
Percentage of Regular Prior Authorizations (PAs) Completed Within 14 Calendar Days of Request



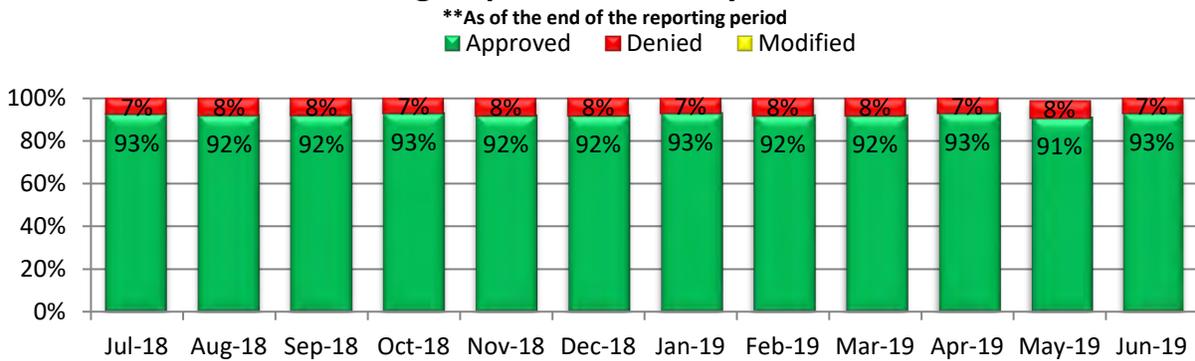
Average Days for Regular PA Processing



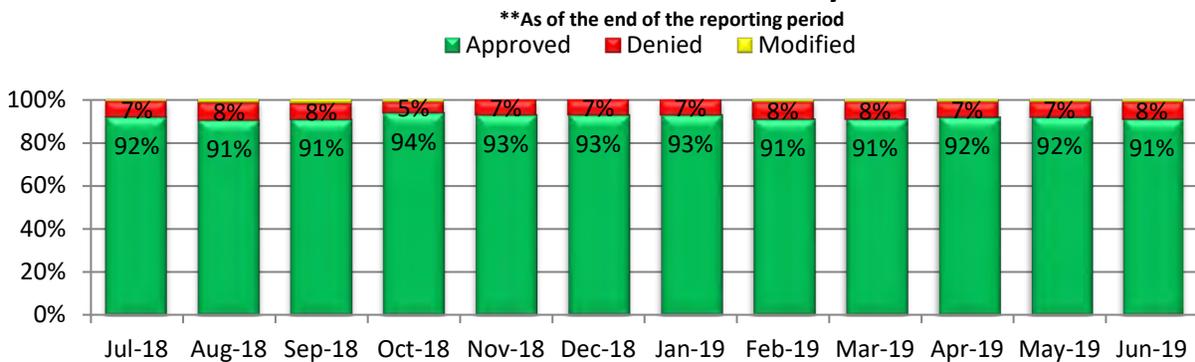
Percentage of PAs for Expedited Services Completed Within 72 Hours of Request



Amerigroup Non-Pharmacy PAs Status



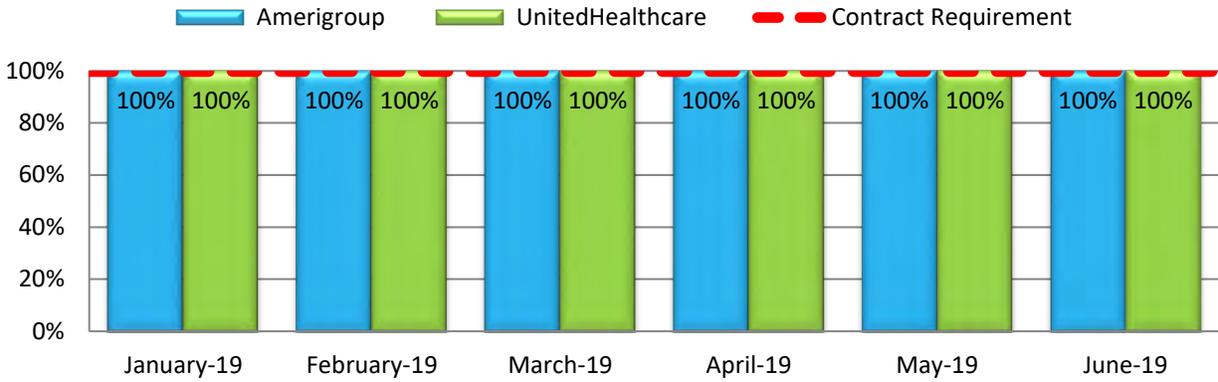
UnitedHealthcare Non-Pharmacy PAs Status



The Department has found and corrected an error in reporting percentages for Non-Pharmacy PA Status from October 2018 – March 2019. The graphs above contain the correct percentages.

Prior Authorization - Pharmacy

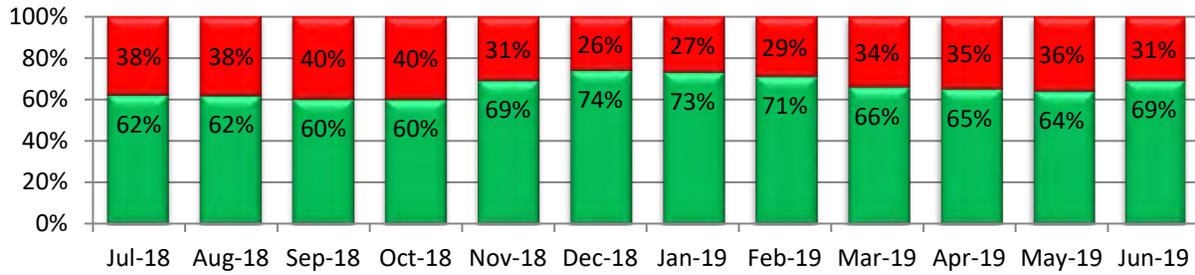
Percentage of Regular PAs Completed Within 24 Hours of Request



Amerigroup Pharmacy PAs Submitted Status

**As of the end of the reporting period

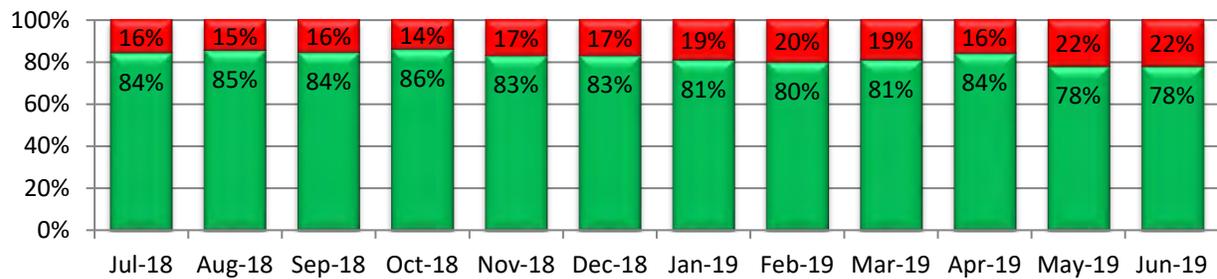
■ Approved ■ Denied



UnitedHealthcare Pharmacy PAs Submitted Status

**As of the end of the reporting period

■ Approved ■ Denied



Encounter Data Reporting

Encounter Data are records of medically-related services rendered by a provider to a member. The Department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

Performance Measure	Amerigroup			UnitedHealthcare		
Encounter Data Submitted By 20 th of the Month	Apr	May	Jun	Apr	May	Jun
	Y	Y	Y	Y	Y	Y

Value Based Purchasing Enrollment

MCOs are expected to have 40% of their population covered by a value based purchasing agreement by the end of Calendar Year 2018.

Data as of June 2019	Amerigroup	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards	47%	54%

MLR/ALR/Underwriting

MCOs are required to meet a minimum medical loss ratio of 88% per the contract between the Department and the MCOs.

- Medical loss ratio (MLR) reflects the percentage of capitation payments used to pay medical expenses.
- Administrative loss ratio (ALR) reflects the percentage of capitation payments used to pay administrative expenses.
- Underwriting ratio reflects profit or loss.

A minimum medical loss ratio protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. A minimum medical loss ratio also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference.

Q4 SFY19 Data	Amerigroup	UnitedHealthcare
MLR	98.1%	92.2%
ALR	6.2%	9.1%
Underwriting	-4.3%	-1.3%

These measurements may be subject to change after the end of the reporting quarter due to out of period adjustments made by the MCOs.

Capitation Payments Made to the Managed Care Organizations

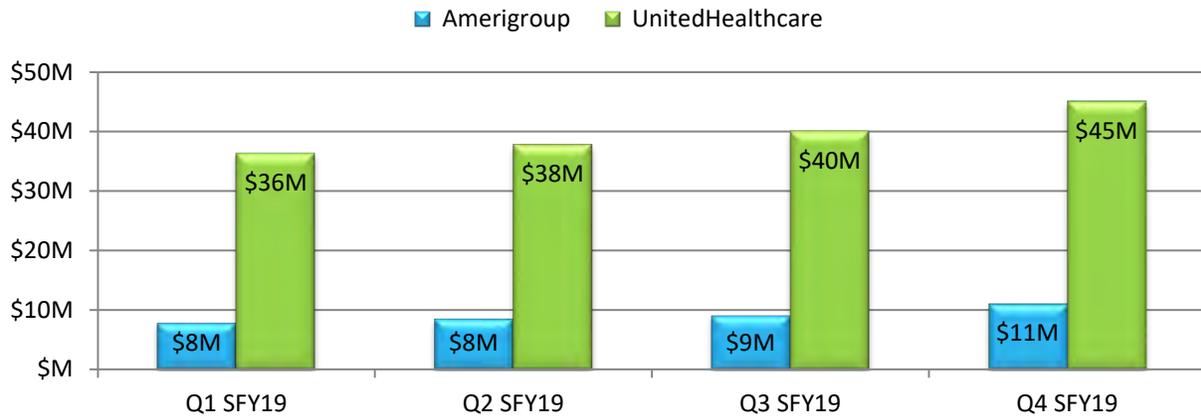
Capitation payments include payments made for the reported quarter's enrollment, adjustments, and member reinstatements and retroactive eligibility. Quarterly Performance Reports in previous fiscal years only included payments for the current quarter's enrollment, which is why previous quarters are not provided.

MCO	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Amerigroup Total	\$417,598,591	\$429,046,037	\$376,525,389	\$402,424,413
Adjustments	\$97,848,029	\$72,262,766	(\$509,327)	(\$313,567)
Current	\$312,420,560	\$347,223,304	\$365,336,282	\$391,378,265
Member Reinstatements and Retroactive Eligibility	\$7,330,002	\$9,559,966	\$11,698,434	\$11,359,715
UnitedHealthcare Total	\$768,872,756	\$865,012,150	\$763,249,472	\$497,225,366
Adjustments	\$78,327,083	\$121,133,543	\$673,460	(\$604,321)
Current	\$671,528,707	\$722,723,962	\$738,949,197	\$483,286,115
Member Reinstatements and Retroactive Eligibility	\$19,016,967	\$21,154,644	\$23,626,815	\$14,543,572

Managed Care Organization Reported Reserves

Data reported	Amerigroup	UnitedHealthcare
Acceptable Quarterly Reserves per Iowa Insurance Division (IID) (Y/N)*	Y	Y

Third Party Liability Recovery (Millions)



Program Integrity

Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the-art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems which have a series of edits that reject inaccurate or duplicate claims.

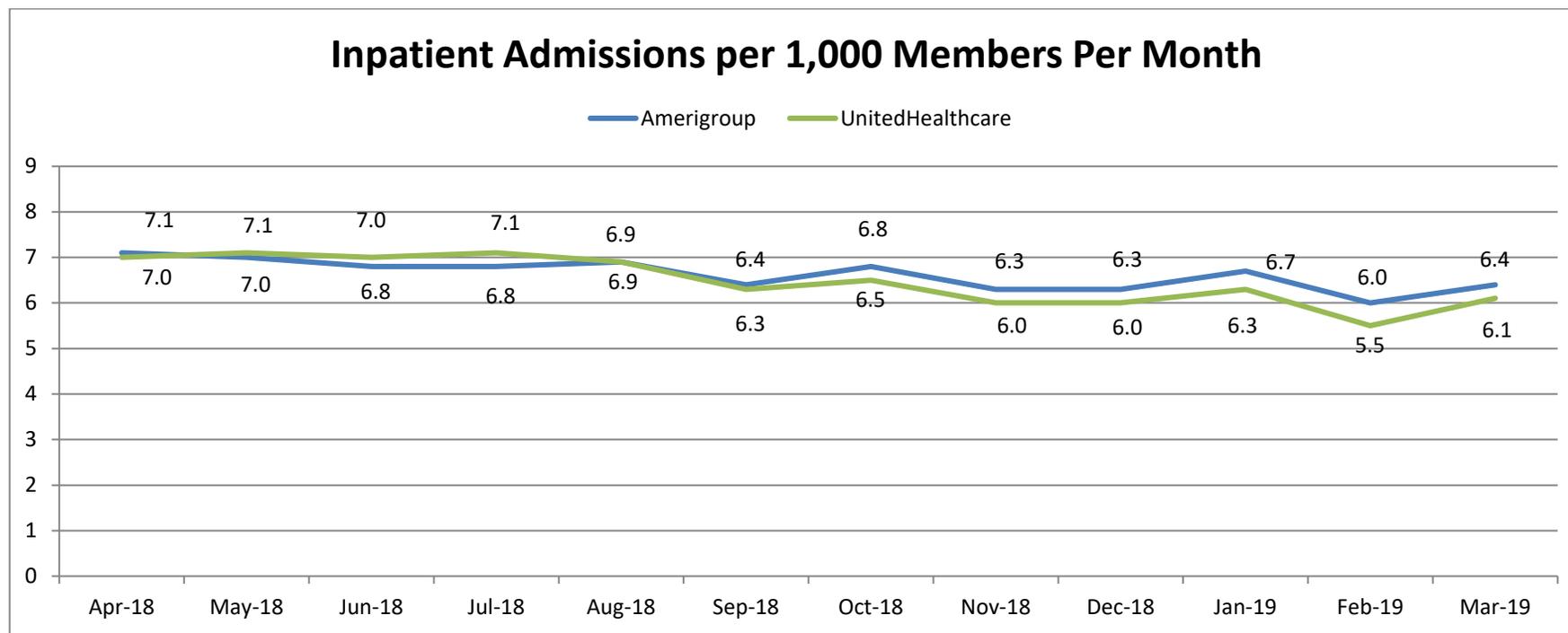
Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

Fraud, Waste and Abuse

Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.

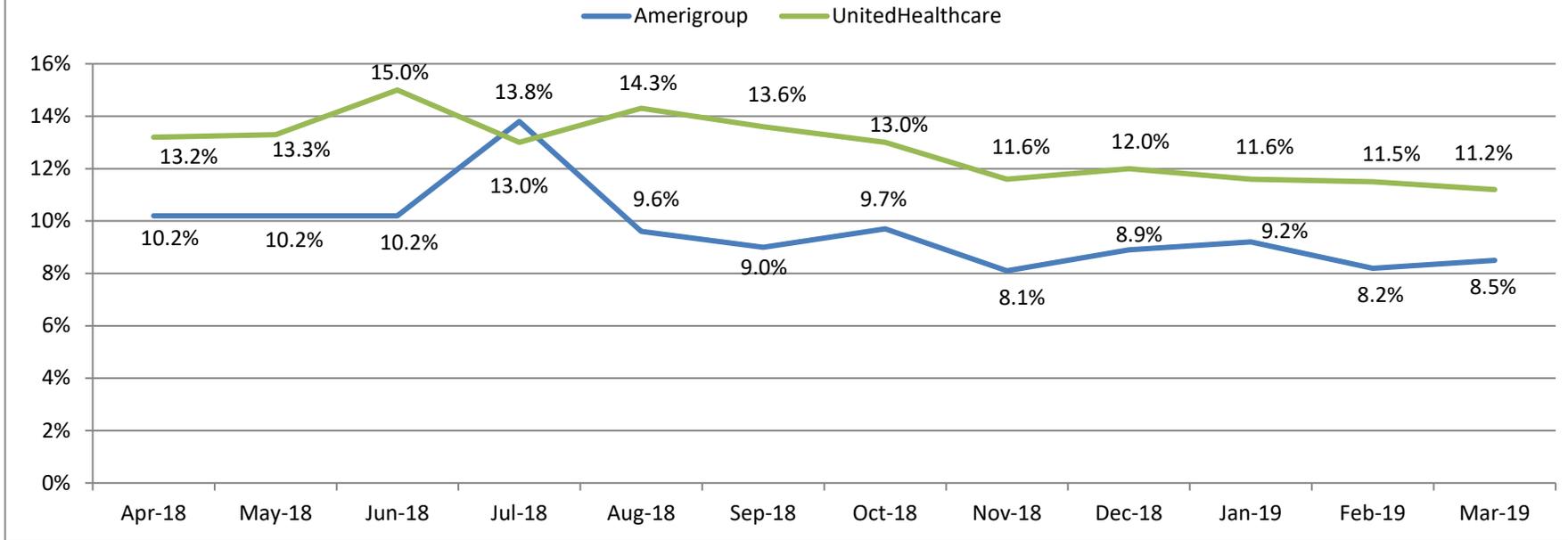
Q4 SFY19 Data	Amerigroup	UnitedHealthcare
Investigations Opened During the Quarter	30	12
Overpayments Identified During the Quarter	14	10
Cases Referred to the Medicaid Fraud Control Unit (MFCU) During the Quarter	15	16
Member Concerns Referred to the IME	8	12

In prior reports, dollars recovered through program integrity efforts were reported on a quarterly basis. However, the MCOs may not collect overpayment until review by the agency has been completed to assure law enforcement activities have been conducted. Given the review and approval process required by the state to collect dollars, recoveries may occur at a much later date. Due to the complexity of actual collection of dollars, recovery of overpayments will be reported on an annual basis. The plans have initiated 42 investigations in the fourth quarter and referred 31 cases to MFCU. The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse; therefore, MCO investigations, overpayment recovery, and referrals to MFCU would not occur until there is sufficient evidence to implement.



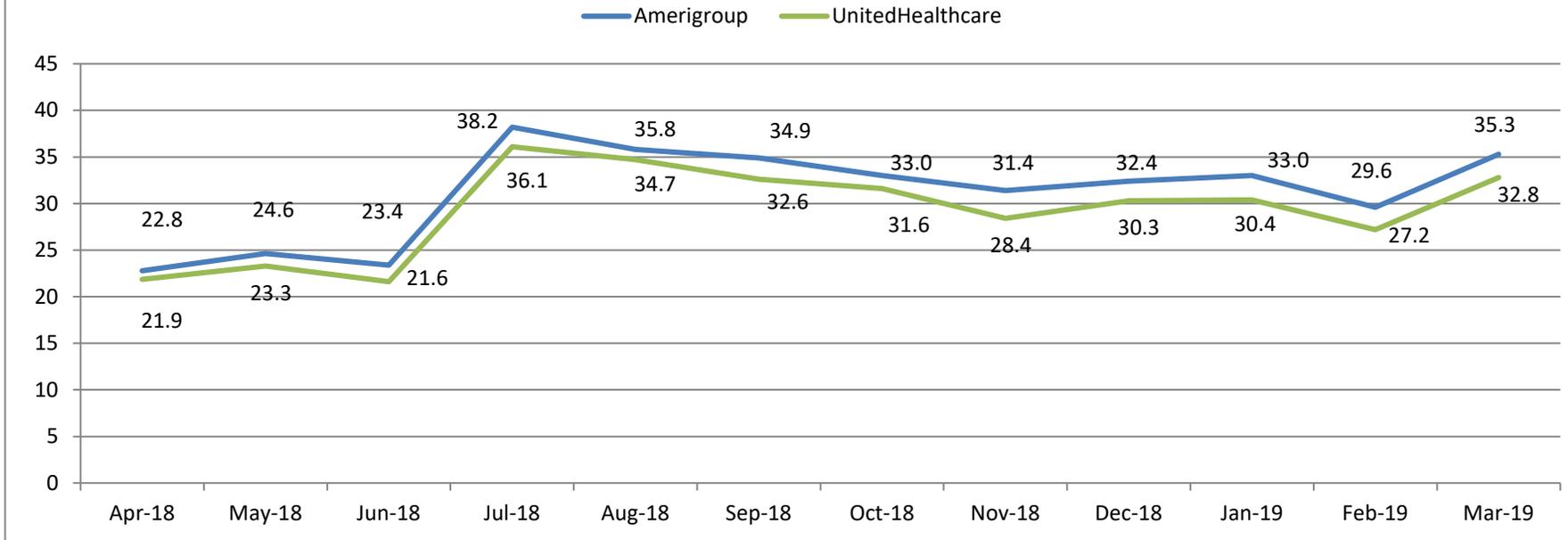
Encounter Data Disclaimer: The data provided by the IME is provided “as is.” The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user’s interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user’s needs or expectations.

All Cause Readmissions within 30 Days



Encounter Data Disclaimer: The data provided by the IME is provided “as is.” The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user’s interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user’s needs or expectations.

Adult Non-Emergent ED Use Per 1,000 Member Months



Encounter Data Disclaimer: The data provided by the IME is provided “as is.” The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user’s interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user’s needs or expectations.

As of July 1, 2018, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number of ED visits considered non-emergent would increase for dates of service after that release.

As of January 1, 2019, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number of ED visits considered non-emergent would increase for dates of service after that release.

APPENDIX

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.

UHC: UnitedHealthcare Plan of the River Valley Iowa, Inc.

Glossary Terms:

Administrative Loss Ratio: The percent of capitated rate payment or premium spent on administrative costs.

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO.

Actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required time-frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network.

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with the Department of Human Services (DHS) or they may ask to ask for a state fair hearing.

Appeal process: The MCO process for handling of appeals, which complies with:

- The procedures for a member to file an appeal;
- The process to resolve the appeal;
- The right to access a state fair hearing, and;
- The timing and manner of required notices.

Calls Abandoned: Member terminates the call before a representative is connected.

Capitation Payment: Medicaid payments the Department makes on a monthly basis to MCOs for member health coverage. MCOs are paid a set amount for each enrolled person assigned to that MCO, regardless of whether services are used that month. Capitated rate payments vary depending on the member's eligibility.

CARC: Claim Adjustment Reason Code. An explanation why a claim or service line was paid differently than it was billed. A **RARC** – Readjustment Advice Remark Code provides further information.

Care Management: Care Management helps members manage their complex health care needs. It may include helping a member get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

Clean Claims: The claim is on the appropriate form, identifies the service provider that provided the service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing facility or home supports.

Community-Based Case Management (CBCM): Community-Based Case Management helps Long-Term Services and Supports (LTSS) members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. Community-Based Care managers (CBCMs) make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (CDAC): Consumer Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.

CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

Critical Incidents: When a major incident has been witnessed or discovered, the HCBS provider/case manager must complete the critical incident form and submit it to

the HCBS member's MCO in a clear, legible manner, providing as much information as possible regarding the incident.

Denied Claims: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

DHS: Iowa Department of Human Services

Disenrollment: Refers to members who have chosen to change their enrollment with one MCO to an alternate MCO.

Durable Medical Equipment: Durable Medical Equipment (DME) is reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

ED: Emergency department

Emergency Medical Condition: An Emergency Medical Condition is any condition that the member believes endangers their life or would cause permanent disability if not treated immediately. A physical or behavioral condition medical condition shown by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of medical attention right away to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or body part.

If a member has a serious or disabling emergency, they do not need to call their provider or MCO. They should go directly to the nearest hospital emergency room or call an ambulance.

The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Covered inpatient or outpatient services that are:

- Given by a provider who is qualified to provide these services.
- Needed to assess and stabilize an emergency medical condition.

Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Fee-for-Service (FFS): The payment method by which the state pays providers for each medical service given to a patient; this member handbook includes a list of services covered through FFS Medicaid.

Fraud: An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; this member handbook tells members how to report fraud.

Good Cause: Members may request to change their MCO during their 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.

Some examples of Good Cause for disenrollment include:

- A member's provider is not in the MCO's network.
- A member needs related services to be performed at the same time. Not all related services are available within the MCO's provider network. The member's primary care provider or another provider determined that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's health care needs.
- The member's provider has been terminated or no longer participates with the MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by the member's MCO.
- The MCO plan does not cover the services the member needs due to moral or religious objections.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30

calendar days from the date the matter occurred. Examples include but are not limited to:

- The member is unhappy with the quality of your care.
- The doctor who the member wants to see is not an MCO doctor.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by the MCO.
- Rights and dignity.
- The member is commended changes in policies and services.
- Any other access to care issues.

Habilitation Services: Habilitation Services are HCBS services for members with chronic mental illness.

HCBS: Home and Community Based Services, waiver services. Home and Community Based Services (HCBS) provide supports to keep Long-Term Services and Supports (LTSS) members in their homes and communities.

Hawki: A program that provides coverage to children under age 19 in families whose gross income is less than or equal to 302 percent of the Federal Poverty Level (FPL) based on Modified Adjusted Gross Income (MAGI) methodology.

Health Care Coordinator: A Health Care Coordinator is a person who helps manage the health of members with chronic health conditions.

Health Risk Assessment (HRA): A Health Risk Assessment (HRA) is a short survey with questions about the member's health.

Historical Utilization: A measure of the percentage of assigned members whose current providers are part of the managed care network for a particular service or provider type based on claims history.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides and therapists.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services
- Observation services
- Outpatient surgery
- Lab tests.
- X-rays

ICF/ID: Intermediate Care Facility for Individuals with Intellectual Disabilities.

IHAWP: Iowa Health and Wellness Plan covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act.

IID: Iowa Insurance Division.

IME: Iowa Medicaid Enterprise.

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Level of Care (LOC): Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long-Term Services and Supports (LTSS): Long-Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.

Long Term Care Services:

- Home and Community Based Services (HCBS)
- Intermediate Care Facilities for Persons with Intellectual Disabilities
- Nursing Facilities and Skilled Nursing Facilities

MCO: Managed Care Organization.

Medical Loss Ratio (MLR): The percent of capitated rate payment or premium spent on claims and expenses that improve health care quality.

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: Each MCO has a network of providers across Iowa who their members may see for care. Members don't need to call their MCO before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the MCO network. There may be times when a member needs to get services outside of the MCO network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to the member than if provided in-network.

NF: Nursing Facility.

PA: Prior Authorization. Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription.

PCP: Primary Care Provider. A Primary Care Provider (PCP) is either a physician, a physician assistant or nurse practitioner, who directly provides or coordinates member health care services. A PCP is the main provider the member will see for checkups, health concerns, health screenings, and specialist referrals.

PDL: Preferred Drug List.

Person-centered Plan: A Person-centered Plan is a written individual plan based on the member's needs, goals, and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP) or individual education plan (IEP).

PMIC: Psychiatric Medical Institute for Children.

Rejected Claims: Claims that don't meet minimum data requirements or basic format are rejected and not sent through processing.

SMI: Serious mental illness.

SED: Serious emotional disturbance. Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.

SED does not include:

- Neurodevelopmental disorders
- Substance-related disorders
- Other conditions that may be a focus of clinical attention, unless they co-occur with another (SED).

Service Plan: A Service Plan is a plan of services for HCBS members. A member's service plan is based on the member's needs and goals. It is created by the member and their interdisciplinary team to meet HCBS waiver criteria.

Skilled Nursing Care: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. The member must be medically and financially eligible. If the member's care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding their care, then a skilled level of care is assigned.

Supported Employment: Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Suspended Claims: Claim is pending internal review for medical necessity and/or may need additional information to be submitted for processing.

TPL: Third-party liability. This is the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Underwriting: A health plan accepts responsibility for paying for the health care services of covered individuals in exchange for dollars, which are usually referred to as premiums. This practice is known as underwriting. When a health insurer collects more premiums than it pays in expense for those treatments (claim costs) and the expense to run its business (administrative expenses), an underwriting gain is said to occur. If the total expenses exceed the premium dollars collected, an underwriting loss occurs.

SOUP OF THE DAY**SUNDAY**

CHICKEN NOODLE

MONDAY

TUSCAN WHITE BEAN (VEGAN)

TUESDAY

VEGGIE TORTELLINI (VEGETARIAN)

WEDNESDAY

PEPPER JACK POTATO (VEGETARIAN)

THURSDAYTOMATO BASIL BISQUE
(VEGETARIAN)**FRIDAY & SATURDAY**

CLAM CHOWDER

\$3.50 / \$4.99**PICK TWO****PICK ONE**SMALL DELI SANDWICH OR SMALL
WRAP**PLUS**REGULAR SALAD (MARKET OR
CAESAR)

SUB CRANBERRY WALNUT: +\$1

SUB GREEK, CILANTRO LIME,
SANTA FE OR PEANUT CHICKEN
SALAD: +\$3**\$9.99****TODAY'S SOUPS****EVERYDAY**

CHICKEN CORN TORTILLA

VEGGIE CHILI (VEGAN)

\$3.50 / \$4.99**MAKE ANY SALAD AN
ENTRÉE**ADD FALAFEL / CHICKEN (GRILLED,
BLACKENED OR FRIED) / SPICED
SEITAN +\$3ADD SHRIMP (GRILLED, BLACKENED
OR FRIED) +\$5**THE MARKET**Greens, feta, tomato, onion, carrot,
cucumber, roasted garlic vinaigrette**\$6.50 / \$9.50****GREEK SALAD**Greens, cilantro tabouli, cucumber, red
onion, onion, tomato, kalamata olives,
red pepper hummus, feta, toasted pita,
roasted garlic vinaigrette**\$9.99 / \$13.99****CRANBERRY WALNUT**Greens, Gorgonzola, spiced walnuts,
red onion, dried cranberries, balsamic
vinaigrette**\$7.50 / \$10.99****CAFE CAESAR**Romaine, parmesan, focaccia
croutons, Caesar dressing**\$6.50 / \$9.50****CILANTRO LIME
CHICKEN**Greens, grilled chicken, parmesan,
onion, tomato, carrot, corn relish,
avocado, fried tortilla strips, cilantro
lime vinaigrette**\$9.99 / \$13.99****PEANUT CHICKEN**Greens, grilled chicken, carrot,
cucumber, onion, bean sprouts,
roasted peanuts, cilantro, spicy peanut
dressing**\$9.99 / \$13.99****SANTA FE CHICKEN**Greens, blackened chicken, cheddar,
black bean salsa, corn relish, tomato,
red onion, avocado, fried flour tortilla
shell, chipotle ranch dressing**\$9.99 / \$13.99**

DELI SANDWICHES

Served with a pickle spear and choice of fries, chef case side, cup of soup, petite Market, Caesar or Cranberry Walnut salad. Sub sweet potato waffle fries (+ \$1.50) or onion rings (+ \$2.50).

CHICKEN BACON PANINI

Monterey jack cheese, tomato, guacamole, buttermilk parmesan dressing, country Italian bread

\$9.50 / \$11.50

TURKEY DELI

Rotisserie turkey, Swiss, tomato, avocado, lettuce, grain mustard, multigrain bread

\$8.50 / \$10.50

TURKEY BACON CLUB

Rotisserie turkey, bacon, Swiss, 1000 island dressing, lettuce, tomato, country Italian bread

\$9.50 / \$11.50

PORK BELLY CUBANO

Smoked ham, smoked roasted pork belly, Swiss, pickle, onion, mayo, mustard, baguette

\$8.99 / \$10.99

REUBEN

Corned beef, sauerkraut, Swiss, 1000 island dressing, rye bread

\$9.50 / \$11.50

HOT ITALIAN SUB

Salami, roast beef, cappicola, mortadella, provolone, banana pepper rings, lettuce, tomato, onion, roasted garlic vinaigrette, baguette

\$8.50 / \$10.50

WRAPS

CRANBERRY CHICKEN SALAD WRAP

Roasted chicken, cranberry, celery, mayo, greens, flour tortilla

\$8.99 / \$10.99

MEDITERRANEAN WRAP

(Vegetarian) hummus, tabouli, feta, greens, onion, tomato, cucumber, kalamata olives, roasted garlic vinaigrette, flour tortilla

\$8.50 / \$10.50 (ADD FALAFEL +\$3)

CHICKEN COBB WRAP

Fried or grilled chicken, bacon, hard-boiled egg, gorgonzola, avocado, tomato, green goddess dressing, greens, flour tortilla

\$9.50 / \$11.50

PLANT-BASED

Vegan; served with a pickle spear and choice of fries, chef case side, cup of soup, petite Market, Caesar or Cranberry Walnut salad. Sub sweet potato waffle fries (+ \$1.50) or onion rings (+ \$2.50).

**BLACK BEAN BURGER
(VEGAN)**

Black bean burger, guacamole, lettuce, tomato, onion, chipotle ketchup, 9-grain bun

\$11.99**BEYOND MEAT BURGER
(VEGAN)**

Beyond Burger® patty, vegan American cheese, lettuce, tomato, onion, pickle, vegan 1000 Island dressing, ciabatta bun

\$10.99**TOFU BANH MI
(VEGAN)**

Barbecued tofu, vegannaise, Sriracha, carrot, cucumber, cilantro, South Union Bakery baguette

\$9.50**BBQ JACKFRUIT
(VEGAN)**

pulled jackfruit, BBQ sauce, vegan coleslaw, ciabatta bun

\$9.99**BURGERS & SANDWICHES**

Served with a pickle spear and choice of fries, chef case side, cup of soup, petite Market, Caesar or Cranberry Walnut salad. Sub sweet potato waffle fries (+ \$1.50) or onion rings (+ \$2.50).

**ALL-AMERICAN
BURGER**

Two grilled quarter pound George's Grind burgers*, American cheese, 1000 island, lettuce, tomato, onion, sliced pickle, sesame bun

\$11.99 (ADD BACON + \$1)**GATEWAY BURGER**

8 oz. George's Grind burger*, choice of Swiss, cheddar, American, pepper jack, or monterey jack cheese, mayo, lettuce, tomato, onion, sesame bun

\$11.99 (ADD BACON + \$1)**VEGGIE BURGER
(VEGETARIAN)**

Veggie burger, lettuce, tomato, chipotle ranch dressing, onion rings, ciabatta

\$9.99**GRILLED CHICKEN CLUB**

Bacon, pepper jack, bbq sauce, lettuce, tomato, onion, 9-grain bun

\$10.99**MUSHROOM SWISS
BURGER**

8 oz. George's Grind burger*, Swiss, sautéed mushroom and onion, rosemary mushroom beef gravy, sesame bun

\$12.99 (ADD BACON + \$1)**NEW ENGLAND
LOBSTER ROLL**

Lobster shrimp salad, New England roll

\$12.99

NASHVILLE HOT CHICKEN SANDWICH

Fried chicken strips, Nashville hot sauce, American cheese, mayonnaise, lettuce, sesame bun

\$8.99

MEMPHIS-STYLE BBQ PORK

Applewood-smoked pulled pork, BBQ sauce, creamy coleslaw, sesame bun

\$8.99

FALAFEL (VEGETARIAN)

Falafel, feta, lettuce, tomato, onion, cucumber, tzatziki sauce, falafel flat bread

\$9.99

IOWA PORK TENDERLOIN

Half-pound pork tenderloin with pickles, onion, sesame bun

\$9.99

KOREAN STEAK

Bulgogi grilled flank steak*, kimchi, cilantro, sriracha mayo, ciabatta

\$12.99

BLACKENED TUNA STEAK

Ahi tuna*, Cajun aioli, lettuce, tomato, onion, ciabatta

\$13.99

NOODLES

HOUSE RAMEN

Sesame miso pork broth, tofu, ramen noodles, carrot, scallion, bean sprouts, spinach, corn, boiled egg*

\$9.99 (ADD CHICKEN, PORK BELLY OR SHRIMP + \$3)

VEGGIE RAMEN (VEGETARIAN)

Sesame miso broth, tofu, ramen noodles, carrot, scallion, bean sprouts, spinach, corn, boiled egg*

\$8.99

SPICY PORK BELLY RAMEN

Roasted smoked pork belly, spicy pork broth, ramen noodles, tofu, kimchi, corn, scallion, sprouts, boiled egg*, spinach

\$12.50

TOKYO RAMEN

Soy pork broth, ramen noodles, corn, scallion, sprouts, spinach, boiled egg*

\$8.99 (ADD TOFU, CHICKEN, PORK BELLY OR SHRIMP + \$3)

PAD THAI (VEGAN, GLUTEN FRIENDLY*)

Rice noodles, tofu, scallion, cilantro, lime, bean sprouts, chopped peanuts, garlic chili sauce

\$9.99 (ADD CHICKEN OR SHRIMP + \$3)

CANTONESE STIR FRY

Egg noodles, carrot, celery, spinach, onion, bell pepper, scallion, garlic, bean sprouts, cilantro, Cantonese brown sauce

\$8.99 (ADD CHICKEN OR SHRIMP + \$3)