**Governor's Developmental Disabilities Council**

*Preparation, Participation and Power.*

December 15, 2010

Governor Chester Culver
State Capitol
1007 East Grand Ave.
Des Moines, IA 50319

RE: Bill Amendments for HF 2526, Section 27 Residential Care Facilities.

Dear Governor Culver:

Please find attached the report of findings and recommendations from the review of the status of residential care facilities in Iowa and the services provided pursuant to the request in Bill Amendments for HF 2526, Section 27. In addition to the findings and recommendations, a legislative history related to Residential Care Facilities is also attached for your reference.

Respectfully,

Becky Maddy Harker
Executive Director

cc:

Governor-Elect Terry Branstad
Senator Jack Hatch
Representative Lisa Heddens
Representative David Johnson
Representative David Heaton
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GOVERNOR'S DEVELOPMENTAL DISABILITIES COUNCIL

# RESIDENTIAL CARE FACILITIES IN IOWA

## Status Review

**12/15/2010**

**Background**

The 2010 session of the General Assembly included in HF 2526 the following directive to the Governor's Developmental Disabilities Council concerning a study of Residential Care Facilities in Iowa. The language was included in the bill at the request of Representative Lisa Heddens as the result of several meetings with the principal stakeholders from the Iowa Departments of Human Services, Inspections and Appeals, and Aging. Specifically the language stated:
Bill Amendments for HF 2526, Section 27

> *"7. The governor's developmental disabilities council is requested to facilitate a workgroup of stakeholders to review the status of residential care facilities in the state and the services provided. The membership of the workgroup may include but is not limited to representatives of county central point of coordination administrators, the departments of aging, human services, and inspections and appeals, the office of the citizens' aide and other legislative agencies, and the judicial branch. The issues considered by the workgroup may include identifying the characteristics of clients served such as age, disability, reason for admission and level of care provided; the reasons why such facilities have been closing or downsizing and where clients were placed; the types and usage of alternatives to the facilities; the types of services provided to clients such as Medicaid waiver, rehabilitation, mental health, and aging services; workforce employed by the facilities; client access to health care; financing; and practices used for court-ordered placements. The workgroup shall report, providing findings and recommendations, to the governor and persons designated by this Act for submission of reports on or before December 15, 2010."*

The Governor's Developmental Disabilities Council convened two initial planning meetings that included representatives of the three agencies to determine sources of additional data and their relevance to the task, including engaging a larger group of stakeholders. The result of the June 14th meeting was a survey sent to 188 Residential Care Facilities (RCFs) to gather information about the number of beds, clients served and staffing. County Central Point of Coordination Administrators (CPCs) in Counties where 46 Residential Care Facilities (RCF's) had closed in the past three years were also asked to report their observations about the closure of RCFs in their Counties. An August 26th meeting of the planning group was held to review the results of the survey, the information on closures from the CPCs and to plan for the subsequent public meeting to gather further input.

A public meeting of stakeholders was convened on September 22 to further evaluate the information gathered and address issues identified by the RCF survey respondents. Stakeholders invited to participate included the following agencies: Iowa Association of Community Providers, Iowa State Association of Counties, Iowa Health Care Association, Iowa Association of Homes & Services for Aging, Iowa Department of Public Health, Office of Citizen's Aid Ombudsperson, Iowa Veterans, Governor's Office, Legislative Services Agency, Central Iowa Providers, Judicial, and Disability Rights Iowa Stakeholders were invited to provide written and/or oral comments related to the areas identified in the legislation. Twenty two stakeholders attended that meeting with the majority representing RCFs. A subsequent meeting of stakeholders was held on October 29th and stakeholders were invited to provide

public comment on the draft plan, specifically the recommendations. Twenty three people attended the session. A final draft was prepared as a result and sent to stakeholders for a final review and comment period via e-mail.

**Overview of Residential Care Facility Characteristics**

RCF Types

There are three types of Residential Care Facilities (RCFs) in Iowa and a separate set of licensing requirements that regulate each:

RCF- Iowa Administrative Code 481 – Chapter 57-[residential care for a general population]

RCF/MR- Iowa Administrative Code 481 – Chapter 63-[residential care for the mentally retarded (intellectually disabled)]

RCF/PMI- Iowa Administrative Code 481 – Chapter 62-[residential care for the mentally ill]

Definition

Iowa Residential Care Facilities (RCFs) are premises that provide congregate housing to three or more people (residents) not related to the owner or administrator within the third degree of consanguinity (relationship). RCFs provide a structured living environment where only minimal assistance and supervision is required and the residents get their needs meet through the assistance and supervision provided by the facility's employees.

Structure

The physical structures that house Iowa RCFs range from residential homes in neighborhoods to institutional type settings. RCFs, regardless of license type must, at the time of initial licensure, be compliant with the "minimum" physical standards outlined in Iowa Administrative Code 481 – chapter 60 or be covered by one of the designated exceptions, which means, in various sections of the rules specific provisions for existing structures differ from those for new construction and are designated by a notation at the end of the applicable rule as follows:

*a.* Exception 1: Rule does not pertain to facilities licensed for less than 16 beds; or units housing fewer than 16 beds which are in distinctly separate buildings, located on a contiguous parcel of land, separated only by a public or private street.

*b.* Exception 2: Rule does not pertain to facilities licensed before May 1, 1972.

*c.* Exception 3: Rule does not pertain to facilities with construction plans approved by the department before May 1, 1977.

*d.* Exception 4: Rule does not pertain to facilities licensed before March 30, 1988.

*e.* Exception 5: Rule does not pertain to facilities licensed as residential care facilities for eight or fewer beds.

*f.* Exception 6: Rule does not pertain to facilities built according to plans approved by the department prior to May 6, 1992.

RCFs that are 3 to 5 bed special licenses do not need to meet Chapter 60. They need to be located in an area zoned for single or multi-family housing, or be located in an unincorporated area. They shall be constructed in compliance with applicable local housing codes and the rules adopted for this classification of license by the SFM.

Fire Safety

Licensed Residential Care Facilities receive an annual fire safety inspection under a 28E agreement between the Department of Inspections and Appeals (DIA) and the Department of Public safety (DPS). The fire safety inspections may be conducted by the local fire authority in the particular town where the facility is located. The fire safety inspections are based on requirements of 2009 Edition of the International Fire Code or the local fire safety regulations which ever is most stringent.

Provision of Services

RCFs provide (under a contract each person effectuates, prior to or, at the time of admission) accommodation (provision of lodging that includes sleeping, dining and living areas), board (regular provision of meals) and personal assistance with activities of daily living (ADLs) which the person only has some difficulty performing; (examples include but are not limited to; getting out of bed, personal hygiene, bathing, dressing, eating and other essential activities of daily living; (ie; transportation, socialization, etc). The services provided by an RCF, and the implementation of such, are based on a written, department approved, program of care document. The program of care is in accord with minimum licensure requirements that are specified in the IAC chapter applicable to a facilities licensure type (reference above).

Living in an RCF is a matter of choice for most residents, however some residents reside in a RCF as result of a court-order and some as result of a mental health commitment.

Staffing

RCFs are staffed 24 hours a day, seven days a week. The number and qualifications of staff depend on the licensure category specified above. There is no requirement for a licensed nurse to be on duty, and there is no requirement that the staff be certified nursing assistants in any of the RCF licensure categories. The staff that is on duty must be oriented/trained to assure they can provide the assistance/supervision required for the individual residents and are able to provide the services outlined in the facility's approved program of care and facility policies. Staff are responsible for assuring resident needs are met. When medication administration is

necessary it is required that a facility licensed for more than 15 beds employee a Certified Med Aide to administer medications and a facility that is 15 or less beds may employee a med manager to administer medications.

Administration

The owner of a RCF is not required to live on site. The owner is required to hire an administrator that is responsible for the facility's operation on a 24/7 basis. The owner may be the administrator. The administrator must be approved by the Department and shall be: a licensed nursing home administrator, a licensed residential administrator or have two years of supervised experience in a residential care facility, at least six months of which was in an administrative capacity. There are different requirements for administrators in the different licenses. Chapter 63 allows an administrator to be a QMRP as opposed to the 2 years of experience in a residential facility. I Chapter 62 allows an administrator to be a QMHP with one year of experience. Also if you are a NH administrator, you still need 2 years of experience working with people with MI.

Special Considerations

Special variations and considerations may be granted to a residential care facility which is operated for people who have special considerations such as intellectual or physical disabilities, mental illness or a condition in common which can best be treated in a specialized environment under an approved program of care commensurate with the needs of the residents of the facility. Criteria for these specialized programs are established by the Department of Inspections and Appeals, based on the program of care and the numbers and qualifications of staff and the administrator. Such a facility shall be provided with the kind of equipment, numbers of qualified staff, and operated in such fashion as to meet the requirements of the department. On approval of the department, the state fire marshal, the department of human services, or other appropriate agencies, variations from the established rules and regulations for a RCF may be made as is necessary to successfully implement the specialized program, providing that it does not endanger the health, safety, or welfare of any resident and that alternate means to effect the same degree of protection is used when such variances are permitted.

## Findings

Clients

- One hundred twenty eight (128) RCFs out of 188 responded to the survey mailed in July. This is a response rate of 65%. Of the 128, 65 were licensed as an RCF, 4 as an RCF/MI/MR, 44 as a RCF/MR, 11 as a RCF/MI and 4 as "other". (Please note that not all respondents completed all portions of the survey. As a result, numbers do not always add up to the same total. For example, the survey asked about the number of beds and the census for SFY 2010. The total number was 2891. However the total number of males and females by age only totals 2167)

- The census for the last two years has been relatively stable, leaving some 20 percent of the beds unoccupied. The 128 respondents reported a total availability of 3573 beds. The census for those beds in 2009 was 2889 and in 2010 was 2891.
- RCFs reported the largest number of clients in 2010 (2119) followed by 501 in RCFs/MR and 197 RCFs/MI.
- Clients in RCFs tend to be older. The total number reported was 2167. Thirty six percent (36%) of the total were aged 51-70 and 28% were 71 and older.
- The number of males and females overall is relatively even with 48% women and 52% men.
- Overall, women in RCFs are older and men are younger. Of the total number of women, 71% are 51 and older. Of the men, 57% are in this age range. Twenty nine percent of the women are 50 and younger, while 43% of the men are 50 and younger.
- The majority of admissions to the RCFs are voluntary. Of those reporting, 71% of admissions were voluntary and 28% court ordered. Eighteen admissions or 1% were identified as "other."
- The majority of clients in RCFs have a diagnosis of Mental Illness. Mental Illness was reported as a diagnosis for 1126 clients, mental retardation for 535, and dementia for 263. Dual diagnosis was reported for 459 clients but the survey did not ask what specifically constituted a dual diagnosis.
- Most clients of RCFs are on medication and need assistance to take it. Of the total reported, 80% take medications. Eight percent of those take Schedule II medication and 10% self-administer their medications.
- RCFs responding to the survey reported 862 discharges in 2010. The majority of those were transferred to another type of facility such as a skilled nursing facility, a nursing facility, or an assisted living facility. Others were discharged to home, another RCF, or a mental health facility. Twelve were court ordered emergency involuntary discharges and 4 transferred from the RCF to Jail.

Reasons for Recent Closures or Downsizing

Forty one RCFs with a combined total of 941 beds have closed or downsized during the past 6 years. The Bed Capacity ranged from 5 to 63. The larger facilities included some formerly operating as the County Care Facility or "County Home". Reasons for closure and downsizing were solicited from providers and County staff. Reasons for changes included:

- Lack of referrals from Targeted Case Managers
- Facilities converted to smaller Medicaid Waiver homes
- Clients desire to live in less restrictive settings in the community
- Financial reasons, staff, cost of repairs, foreclosure
- Accepting very difficult clients and it finally "got out of hand"
- Part of the County's strategic Plan
- Failed DHS or DIA reviews

- Difficulty finding and keeping staffs
- Shift to Waiver Services
- Reduced Census
- Converted beds to a Nursing Facility

What Happened to Clients?

- Relocated to other RCFs
- Moved to less restrictive Community settings/transitional apartments/Waiver Service Homes
- Moved to Nursing Facilities (elderly)
- Moved to an ICF/MR

## Concerns/Challenges

Resident/Client Characteristics

When polled about the concerns and challenges facing RCF's in Iowa, "Resident/client characteristics" was one of the top three identified by survey respondents. Those included:

- Increased acuity of clients without proper support or treatment, (e.g. mental illness, behavioral issues, substance and alcohol abuse), co-occurring mental health and substance abuse, unstable clients with limited psychiatric services. These clients are more difficult to serve and there are more legal issues with these clients.
- Multiple health concerns in people around 50 years of age and older
- Young people don't want to live in congregate settings
- People are living at home longer and when they need assistance it tends to be for a higher level of care
- People who don't qualify for county funding but do need care

Funding

Survey respondents reported that reimbursement rates do not support the service expectations or support the actual costs of room and board. Funding sources described as inadequate included Title XIX, County, SSA and HCBS Waiver. Funding was also described as the primary barrier to recruiting, training and retaining a workforce at competitive rates of pay with benefits comparable to other employers in communities.

Staff of the Department of Human Services Division of Mental Health and Disability Services and Iowa Medicaid Enterprise gathered data and information about funding Residential Care Facilities for SFY09.

Typical Profile of Individuals Residing in Residential Care Facilities

1. Person is admitted without any assistance. County pays 100% service and maintenance costs, plus all medical and medication costs (Could be any diagnosis – ID/DD/CMI/Dual Diagnosis)
2. Person is admitted with Social Security (SSI/SSDI). County pays service cost, SSA and person's Social Security (SSI/SSDI)* pays the maintenance cost, and TXIX pays medication and medical cost (Diagnosis – ID/DD/CMI/ Dual Diagnosis)
3. Person is admitted with Social Security (SSI/SSDI). ***HCBS/ID Waiver and the County share service cost, SSA and person's Social Security (SSI/SSDI)* pays the maintenance cost, and Medicaid pays medical and medication. (ID Diagnosis)
4. Person is admitted with Social Security (SSI/SSDI). HCBS/Elderly Waiver and the County share service cost, SSA and person's Social Security (SSI/SSDI)* pays the maintenance cost, and Medicaid pays medical and medication. (**Elderly persons who may or may not have ID/DD/CMI/Dual diagnosis)
5. Person is admitted with Social Security (SSI/SSDI). ***Habilitation Services and the County share service cost, SSA and person's Social Security (SSI/SSDI)* pays the maintenance cost, and Medicaid pays medical and medication. (CMI Diagnosis)
6. Person is admitted with Social Security (SSI/SSDI). County pays service cost, SSA and person's Social Security (SSI/SSDI)* pays maintenance cost, and TXIX pays the medication and medical cost. (Could be any diagnosis – ID/DD/CMI/Dual Diagnosis)
7. Person is admitted and is private pay due to being over income and resource guidelines. All costs (service, maintenance, medical, and medication) are covered by the individual or their family. (Could be any diagnosis – ID/DD/CMI/Dual Diagnosis)

**individuals residing in an RCF are allowed $93.00 a month in personal allowance. The remaining amount of their social security or other income goes toward the RCF maintenance cost.*
*** Elderly individuals without an ID/DD/CMI diagnosis are not funded with county mental health dollars, but rather County General fund dollars*
****Counties fund the non-federal share of the ID waiver and Habilitation Services, the State funds the non-federal share of all other waivers.*

(ID = Intellectual Disability; DD = Developmental Disability; CMI = Chronic Mental Illness; Dual = a combination of disabilities including possibly substance abuse; SSI= Supplemental Security Income; SSDI = Social Security Disability Insurance)

The total of all funding sources (excluding client participation amounts) is $57,236,360. The largest share (51%) is county funding. (This does not include the Non-Federal share of the ID Waiver or Habilitation). Iowa Counties fund 2,577 people in RCFs. Additional funding sources include: Intellectual Disability waiver (30%), SSA (9%), State Payment Program (8%) and all other waivers (2%).
One thousand fourteen (1014) Home and Community Based Services members live in RCFs. 53% are on the ID Waiver, 40% receive Habilitation Services, 5% receive Elderly Waiver while

the remaining 2% receive Brain Injury Waiver or Remedial Services. Counties pay the Non-Federal Share of the ID Waiver and Habilitation Service costs for individuals with Legal Settlement.

Staffing

It's difficult to quantify the staffing of Residential Care Facilities. The survey of RCFs included questions related to the number and type of staff. Because the RCF may be a part of a number of Provider services and facilities, staff is often shared across facilities. A better discussion of staffing issues is provided by issues identified by RCFs through the survey and oral and written public input.

Survey respondents reported that it's difficult to fill staff vacancies with quality and qualified staff without competitive salary and benefits. They reported high turnover of staff and in some areas a limited workforce from which to solicit applicants. Other barriers included training for staff serving high need residents and affordable relevant staff development opportunities.

Regulatory Issues

Other survey respondents also reported discrepancies between RCF and ID Waiver expectations. Several identified paperwork and regulations as a barrier. One respondent summed up comments by saying, "People in the community, even some doctors and social workers don't know or understand RCF level of care." Others indicated this was true of the courts as well due to placements that require more care and skill than a RCF is qualified to provide.

## Recommendations

The role and character of Residential Facilities has changed since they were created in 1947. The legislative history of Residential Care Facilities (RCFs) attached to this report documents the response of the Iowa Legislature to the changing needs of Iowans requiring functional supports to live in communities. Since their inception there has been a steady movement toward people with limitations living in smaller less restrictive environments in the community. This move has been made possible by improved treatment, effective use of supports, funding, and sometimes medications. The Iowa Legislature has responded with opportunities for RCFs to change in response to the desire of Iowans to stay in communities they choose.

Residential Care Facilities have stretched to be responsive to the changing nature of the client needs, as the system of supports and services has evolved to include more home and community-based options. As a result, many RCFs find they are being

called upon to serve individuals with increasingly acute needs while the clientele they formerly served have moved on to other less restrictive settings in the community.

The Iowa General Assembly now has another opportunity to respond to the changing needs of Iowans and shape the role of RCFs in long-term care by directing implementation of the following long and short-term recommendations:

Long Term

Establish a task force to re-examine the long-term care system for Iowans and in that examination, determine the future role and definition of Residential Care Facilities. The task force should:

- Include representatives from DHS, DIA, the Office of the State Long-Term Care Ombudsman, RCFs, and others.
- Review staffing practices, including the need for nurses, certified nursing assistance and certified medication aides.
- Review licensure of facilities to provide care for individuals with special needs (i.e. behavioral challenges, dual diagnosis)
- Examine existing funding resources for long-term services and supports and prioritize investments in infrastructure that ensure that affected Iowans receive the needed level of care and supportive services in the setting of their choice.
- Review current cost reporting requirements and establish a standard reporting system that spans regulatory and funding entities.

Short Term

- Review current Code of Iowa (Chapter 135C) and Iowa Administrative Code (Chapters 57, 62 and 63) and suggest needed changes or modifications.
- Review existing education and training requirements for direct care staff to ensure that they develop skills and competencies to meet the changing needs of residents of all RCF's.
- In addition to the role of CPC's and Case Mangers, ensure that there is a uniform system in place to follow the progress of individuals who are transitioned into other care/ support settings when an RCF is closed. Consider expanding the role

and staffing of the Office of the State Long-Term Care Ombudsman to provide follow-up, advocacy and complaint resolution services for affected residents.

- Encourage the judicial branch to develop a standardized system of appointing and educating magistrates and mental health advocates that increases the consistency of services for individuals who are court-ordered to a RCF.
- Work with DHS and DIA to establish a standard system to allow incident reporting to span all applicable regulatory and funding entities.

## LEGISLATIVE HISTORY OF RESIDENTIAL CARE FACILITIES

Following are key legislative changes related to Residential Care Facilities over the past 63 years:

- In 1947, Iowa Code chapter 135C was created, and Residential Care Facilities were originally established as nursing homes (Acts of the 52nd General Assembly, chapter 92). Nursing home was defined as "any institution, place, building or agency in which accommodation is primarily maintained, furnished, or offered for the care over a period exceeding twenty-four hours of two or more nonrelated aged or infirmed person requiring or receiving chronic or convalescent care and shall include sanatoriums, rest homes, boarding homes or other related institutions within the meaning of this chapter.

The license fee was $10.

- In 1957, nursing homes were divided into two categories – Custodial Home and Nursing Home (Acts of the 57th General Assembly, chapter 93). A Custodial Home was defined as "any institution, place, building or agency which is devoted primarily to the maintenance and operation of facilities for the housing, for a period exceeding twenty-four hours, and for care in excess of food, shelter, laundry or services incident thereto for, two or more nonrelated individuals who are not in need of nursing care or related medical services but who, by reasons of age, illness, disease, injury, convalescence or physical or mental infirmity are unable to care for themselves. Custodial home does not mean hospitals or nursing homes.

License fee for Custodial Home was based on the number of beds:

10 beds or less - $5
10 to 25 beds - $10
25 to 75 beds - $15
75 to 150 beds - $20
150 beds or more - $25

- In 1969, Iowa Code chapter 135C title was changed from "Nursing Homes" to "Health Care Facilities". Adult Foster Home and Boarding Home were added to the definitions. Custodial Home definition was changed to read, "any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, and personal assistance in feeding, dressing, and other essential daily living activities to three or more individuals, not related to the administrator or owner thereof within the third degree of consanguinity, who by reason of age, illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves or manage their own affairs, but who do not require the daily services or a registered or licensed practical nurse. (Acts of the 63rd General Assembly, chapter 1079)

Fees stayed the same as listed in 1957.

Care Review Committees were established.

• In 1975, Custodial Home was changed to Residential Care Facilities. Adult Foster Home and Board Home were deleted. (Acts of the 66th General Assembly, chapter 119)The definition for Residential Care Facilities was modified as follows:

> Custodial Home definition was changed to read, "any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, and personal assistance ~~in feeding, dressing,~~ and other essential daily living activities to three or more individuals, not related to the administrator or owner thereof within the third degree of consanguinity, who by reason of ~~age~~, illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves ~~or manage their own affairs~~, but who do not require the daily services or a registered or licensed practical nurse, <u>except on an emergency basis.</u>

Also, language was added to the Purpose under 135C.2 that allowed for the establishment, by rule, of special classifications of Residential Care Facilities intended to serve individuals who have special health care problems or conditions in common. (Acts of the 66th General Assembly, chapter 119)

Fees were changed to, and remain as such in 2010:

> 10 beds or less - $20
> 10 to 25 beds - $40
> 25 to 75 beds - $60
> 75 to 150 beds - $80
> 150 beds or more - $100

• In 1977, Certificate of Need requirements were established. (Acts of the 67th General Assembly, chapter 75)

• In 1985, language was added to create a classification of Residential Care Facilities intended to serve mentally ill individuals (RCF/PMI). (Acts of 71st General Assembly, chapter 114) In addition, session law created an advisory committee with the Department of Health, Department of Human Services, MH/MR Commission, Commission on the Aging, County MH/MR Coordinating Boards, Providers, Consumer and Advocates. The Advisory Committee was tasked with assisting the Department of Health in the development of appropriate standards of care for RCF/PMI, which recognize the special needs of residents in both short term, transitional RCF/PMI and long-term RCF/PMI.

• In 1986, the Department of Inspections and Appeals was directed to initiate a demonstration waiver project to encourage the development of residential care facilities, which serve persons with mental retardation, chronic mental illness, and other developmental disabilities, which have five or fewer residents for persons specific in section 225C.26. The project was exempt from Certificate of Need through June 30,

1988. The language provided the criteria for granting the waiver. The language also provided for the director of the Department to appoint a temporary waiver committee to provide monitoring of program progress and initial project approval recommendations subject to final approval by the director. The Committee included providers, advocates, counties, and other state agencies. The language allowed for these facilities to be eligible for funding utilized for other classifications of residential care facilities. The total number of waivers was to not exceed a capacity for more than 225 residents before July 1, 1987, no more than 400 by July 1, 1987, and no more than 800 before July 1, 1988. (Acts of the 71st General Assembly, chapter 1246)

- In 1987, the Protection and Advocacy Agency (now Disability Rights Iowa) was added to the chapter related to their authority. (Acts of the 72nd General Assembly, chapter 234)

- In 1988, the 3-5 Bed Demonstration Waiver Project was continued through June 30, 1989. The Waiver Committee was to evaluate the project and make a recommendation to the General Assembly on or before February 15, 1989, whether to continue the project. (Acts of the 72nd General Assembly, chapter 1274)

- In 1989, language was added to create the special Residential Care Facility (RCF) classification for 3 to 5 bed RCFs that had been done as a demonstration project authorized in 1986. The language also formally created a Committee to provide monitoring of the the special classification and the rules and procedures adopted regarding the special classification. The Committee included providers, advocates, counties, and other state agencies. The language allowed for these facilities to be eligible for funding utilized for other classifications of residential care facilities. (Acts of the 73rd General Assembly, chapter 269)

- In 1992, Section 135C.6, subsection 8, was added providing for those residential programs serving not more than three individuals under a home and community-based services waiver or other medical assistance program under chapter 249A, a residential program serving not more than four individuals and operating under the provisions of a federally approved home and community-based waiver for persons with mental retardation and received on-site supervision were not required to be licensed as a health care facility, including a Residential Care Facility.(Acts of the 74th General Assembly, chapter 1043)

- In 1997, language was added to 135C.6, subsection 8, for conversion of twenty Residential Care Facilities for persons with mental retardation to be licensed to serve no more than 5 individuals to home and community-based services. (Acts of the 77th General Assembly, chapter 169)

- In 1998, the 3 to 5 Bed Residential Care Facility Special Classification Committee was eliminated. (Acts of the 77th General Assembly, chapter 1119)

Also, the language done in 1992 under section 135C.6, subsection 8, was modified so that the only residential programs eligible for not being licensed as a health care facility,

including a Residential Care Facility, were those serving four or less individuals under a home and community-based services waiver for the mentally retarded or other medical assistance program under chapter 249A. (Acts of the 77th General Assembly, chapter 1181)

- In 1999, language added to Section 135C.6, subsection 8, in 1997 was modified to allow for the conversion of forty Residential Care Facilities for persons with mental retardation to be licensed to serve no more than 5 individuals to home and community based services. (Acts of the 78th General Assembly, chapter 160)

- In 2004, language added to the definition and description of a Residential Care Facility related to home and community-based services, other than nursing care, being provided, but limits the home and community based services to be provided subject to cost limitations established by the Department of Human Services and are limited in capacity to the number of licensed residential care facilities and beds in the state as of December 1, 2003. (Acts of the 80th General Assembly, chapter 1085)

- In 2010, Senate File 2088 changed the terminology of "persons with mental retardation" to "persons with intellectual disabilities".

Over time there were also technical changes made to terminology and names of entities.