CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—85.1(249A) Acute care in psychiatric hospitals. These rules do not apply to general hospitals with psychiatric units.

85.1(1) *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to rule 481—51.23(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

a. The facility:

(1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.

(2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.

(3) Is accredited as a psychiatric facility by the Joint Commission or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections, appeals, and licensing.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the department.

b. More than 50 percent of all the patients in the facility have mental diseases that require inpatient treatment according to the patient's medical records.

c. A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

d. Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

e. The average patient age is significantly lower than that of a typical nursing home.

f. Part or all of the facility consists of locked wards.

85.1(2) *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to rule 481—51.23(135B) or shall be licensed in another state as a hospital; shall be accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Children and Family Services, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections, appeals, and licensing; and shall meet federal service requirements.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.2(249A) Out-of-state placement. Placement in an out-of-state psychiatric hospital for acute care requires prior department approval and must be approved only if special services are not available in Iowa.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.3(249A) Eligibility of persons under the age of 21.

85.3(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding

the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.3(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

85.3(3) *Certification of need for care.* For persons eligible for Medicaid prior to admission, the need for care shall be certified in accordance with 42 CFR 441.152 (as amended to August 1, 2024). A form prescribed by the department may be used to document these criteria.

a. For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department. A physician's assistant or advanced registered nurse practitioner may also serve as a member of the plan of care team.

The evaluation must be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.3(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in 441—Chapter 75.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.4(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in 441—Chapter 75.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.5(249A) Client participation. The resident is not liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.6(249A) Responsibilities of hospitals.

85.6(1) *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.
(2) Include a medical history.
(3) Contain a record of mental status.
(4) Note the onset of illness and the circumstances leading to admission.
(5) Describe attitudes and behavior.
(6) Estimate intellectual functioning, memory functioning, and orientation.
(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

85.6(2) *Fiscal records.*

a. A case activity report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.6(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment in accordance with 42 CFR 441.154 (as amended to August 1, 2024).

b. Individual plan of care. An individual plan of care shall be developed and implemented for each recipient in accordance with 42 CFR 441.155 (as amended to August 1, 2024).

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility in accordance with 42 CFR 441.156 (as amended to August 1, 2024). The team may also include a physician's assistant or an advanced registered nurse practitioner.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.7(249A) Psychiatric hospital reimbursement.

85.7(1) *Reimbursement formula.* Acute care in psychiatric hospitals will be reimbursed on a per diem rate based on Medicare principles.

a. The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act (as amended to August 1, 2024).

b. Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9 (as amended to August 1, 2024), and 42 CFR 447.250 (as amended to August 1, 2024). Only those costs are considered in calculating the Medicaid inpatient reimbursement.

c. Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

d. Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

e. Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services (CMS). In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the department within 150 days after the close of the hospital's fiscal year.

f. Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

g. Medicaid reimbursement will be reduced by any payments from a third party toward the cost of a patient's care.

85.7(2) *Medical necessity.* The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions that are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

85.7(3) *Reserve bed day payment.* No reserve bed day payments are made to acute care psychiatric hospitals.

85.7(4) *Outpatient services.* No coverage is available for outpatient psychiatric hospital services.

These rules are intended to implement Iowa Code section 249A.4.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.

85.8(1) *Facility.* Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee and Independence.

85.8(2) *Basis of eligibility.* To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be eligible for one of the coverage groups listed in 441—Chapter 75.

85.8(3) *Period of eligibility.* A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

85.8(4) *Extent of eligibility.* While on inpatient status, a person eligible under a coverage group listed in rule 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.9(249A) Psychiatric medical institutions for children—conditions for participation. Psychiatric medical institutions for children will be issued a license by the department of inspections, appeals, and licensing under Iowa Code chapter 135H and will hold either a license from the department under Iowa Code section 237.3(2)*"a"*(3), or, for facilities that provide substance use disorder treatment, a license from the department under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.10(249A) Eligibility of persons under the age of 21.

85.10(1) *Age.* To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.10(2) *Period of eligibility.* The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

85.10(3) *Certification for need for care.* For persons eligible for Medicaid prior to admission, the need for care shall be certified in accordance with 42 CFR 441.152 (as amended to August 1, 2024). A form prescribed by the department may be used to document these criteria.

a. For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department. A physician's assistant or advanced registered nurse practitioner may also serve as a member of the plan of care team.

The evaluation will be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.10(4) *Financial eligibility for persons under the age of 21.* To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in 441—Chapter 75, except medically needy.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.11(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to 441—Chapter 75.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.12(249A) Responsibilities of facilities.

85.12(1) *Medical record requirements.* The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a PRO determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.12(2) *Fiscal records.*

a. A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.12(3) *Additional requirements.* Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment in accordance with 42 CFR 441.154 (as amended to August 1, 2024).

b. Individual plan of care. An individual plan of care shall be developed and implemented for each recipient in accordance with 42 CFR 441.155 (as amended to August 1, 2024).

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility in accordance with 42 CFR 441.156 (as amended to August 1, 2024). The team may also include a physician's assistant or an advanced registered nurse practitioner.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.13(249A) Outpatient day treatment for persons aged 20 or under. Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections, appeals, and licensing for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

EXCEPTION: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

These rules are intended to implement Iowa Code section 249A.4.

[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.14(249A) Conditions of participation. A nursing facility for persons with mental illness shall be licensed pursuant to 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to rule 481—51.24(135B). A distinct part of a general hospital may be considered a psychiatric institution. In

addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall have 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.15(249A) Out-of-state placement. Placement in out-of-state nursing facilities for persons with mental illness is not payable.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.16(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in 441—Chapter 75, except for medically needy.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.17(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.18(249A) Responsibilities of nursing facility.

85.18(1) *Medical record requirements.* The facility shall obtain a PRO determination that a person requires psychiatric care when the person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.18(2) *Fiscal records.*

a. A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.19(249A) Policies governing reimbursement. Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25]

441—85.20(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness who has countable income for purposes of rule 441—75.16(249A) of less than $55 per month will receive a state-funded payment from the department for the difference between that countable income and $55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.
[**ARC 9312C**, IAB 5/28/25, effective 8/1/25; **ARC 9859C**, IAB 12/24/25, effective 2/1/26]

These rules are intended to implement Iowa Code section 249A.4.

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