

CHAPTER 25  
DISABILITY SERVICES MANAGEMENT

PREAMBLE

This chapter provides for definitions of regional core services; access standards; implementation dates; practice standards; reporting of regional expenditures; development and submission of regional management plans; data collection; applications for funding as they relate to regional service systems for individuals with mental illness, intellectual disabilities, developmental disabilities, or brain injury; and submission of data for Medicaid offset calculations.

[ARC 0576C, IAB 2/6/13, effective 1/8/13; ARC 0735C, IAB 5/15/13, effective 8/1/13; ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 1671C, IAB 10/15/14, effective 9/25/14; ARC 4207C, IAB 1/2/19, effective 3/1/19]

DIVISION I  
REGIONAL SERVICES

**441—25.1(331) Definitions.**

“*Access center*” means the coordinated provision of intake assessment, screening for multi-occurring conditions, care coordination, crisis stabilization residential services, subacute mental health services, and substance abuse treatment for individuals experiencing a mental health or substance use crisis who do not need inpatient psychiatric hospital treatment, but who do need significant amounts of supports and services not available in other home- and community-based settings.

“*Adult*” means the same as defined in 441—subrule 78.27(1).

“*Assertive community treatment*” or “*ACT*” means a program of comprehensive outpatient services consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration, provided in the community and directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of individuals with severe and persistent mental illness and individuals with complex symptomology who require multiple mental health and supportive services to live in the community.

“*Assessment and evaluation*” means the clinical review by a mental health professional of the current functioning of the individual using the service in regard to the individual’s situation, needs, strengths, abilities, desires and goals to determine the appropriate level of care.

“*Brain injury*” means the same as defined in rule 441—83.81(249A).

“*Care coordination*” means facilitating communication and ensuring provision of services among multiple professionals and service providers, the individual, and family members or other natural supports when designated by the individual, and ensuring the individual has the information necessary to actively participate in service and discharge or transition planning.

“*Case management*” means service provided by a case manager who assists individuals in gaining access to needed medical, social, educational, and other services through assessment, development of a care plan, referral, monitoring and follow-up using a strengths-based service approach that helps individuals achieve specific desired outcomes leading to a healthy self-reliance and interdependence with their community.

“*Case manager*” means a person who has completed specified and required training to provide case management through the medical assistance program.

“*Community-based crisis intervention service*” means a program designed to stabilize an acute crisis episode and to restore an individual and family to their pre-crisis level of functioning. Crisis services are available 24 hours a day, 365 days a year, including telephone and walk-in crisis service and crisis care coordination.

“*Comprehensive assessment*” means the same as “crisis assessment” defined in rule 441—24.20(225C) for individuals being referred to crisis stabilization residential services and means the same as “assessment” defined in rule 481—71.2(135G) for individuals being referred to subacute mental health services.

“*Crisis assessment*” means the same as defined in rule 441—24.20(225C).

“*Crisis care coordination*” means a service provided during an acute crisis episode that facilitates working together to organize a plan and service transition programming, including working agreements with inpatient behavioral health units and other community programs. The service shall include referrals to mental health services and other supports necessary to maintain community-based living capacity, including case management as defined herein.

“*Crisis evaluation*” means the process used with an individual to collect information related to the individual’s history and needs, strengths, and abilities in order to determine appropriate services or referral during an acute crisis episode.

“*Crisis intervention plan*” means the same as defined in rule 441—24.1(225C).

“*Crisis screening*” means a brief assessment to make a determination of the presenting problem and referral to the appropriate level of care.

“*Crisis stabilization community-based services*” or “*CSCBS*” means the same as defined in rule 441—24.20(225C).

“*Crisis stabilization residential services*” or “*CSRS*” means the same as defined in rule 441—24.20(225C).

“*Day habilitation*” means services that assist or support the individual in developing or maintaining life skills and community integration. Services shall enable or enhance the individual’s functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

“*Emergency care*” means the same as defined in rule 441—88.21(249A).

“*Emergency detention*” means the same as “immediately detained” as described in Iowa Code section 229.22(1).

“*Evidence-based services*” means using interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial and effective and have established standards for fidelity of the practice.

“*Face-to-face*” means the same as defined in rule 441—24.20(225C).

“*Family psychoeducation*” means services including the provision of emotional support, education, resources during periods of crisis, and problem-solving skills consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“*Family support*” means services provided by a family support peer specialist that assist the family of an individual to live successfully in the family or community including, but not limited to, education and information, individual advocacy, family support groups, and crisis response.

“*Family support peer specialist*” means a parent, primary caregiver, foster parent or family member of an individual who has successfully completed standardized training to provide family support through the medical assistance program or the Iowa Behavioral Health Care Plan.

“*Group supported employment*” means the job and training activities in business and industry settings for groups of no more than eight workers with disabilities. Group settings include enclaves, mobile crews, and other business-based workgroups employing small groups of workers with disabilities in integrated, sustained, paid employment.

“*HCBS*” means home- and community-based services as defined in rule 441—78.27(249A).

“*Health homes*” means a service model that facilitates access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Services may include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.

“*Home and vehicle modification*” means a service that provides physical modifications to the home or vehicle that directly address the medical health or remedial needs of the individual and that are necessary to provide for the health, welfare, and safety of the individual and to increase or maintain independence.

*“Home health aide services”* means unskilled medical services which provide direct personal care. This service may include assistance with activities of daily living, such as helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician.

*“Homeless”* means the same as “homeless person” defined in rule 441—25.11(331).

*“Illness management and recovery”* means a broad set of strategies designed to help individuals with serious mental illness collaborate with professionals, reduce the individuals’ susceptibility to the illness, and cope effectively with the individuals’ symptoms consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

*“Individual”* means any person seeking or receiving services in a regional service system.

*“Individual supported employment”* means services including ongoing supports needed by an individual to acquire and maintain a job in the integrated workforce at or above the state’s minimum wage. The outcome of this service is sustained paid employment that meets personal and career goals.

*“Intake assessment”* means the process used with an individual to collect information related to the individual’s history, needs, strengths, and abilities for the purpose of determining the individual’s need for comprehensive assessment, appropriate services or referral.

*“Integrated treatment for co-occurring substance abuse and mental health disorders”* means effective dual diagnosis programs that combine mental health and substance abuse interventions tailored for the complex needs of individuals with co-morbid disorders. Critical components of effective programs include a comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interviews; provision of help to individuals in acquiring skills and supports to manage both illnesses and pursue functional goals with cultural sensitivity and competence consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

*“Intensive residential service homes”* or *“intensive residential services”* means intensive, community-based services provided 24 hours a day, 7 days a week, 365 days a year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in subrule 25.6(8).

*“Job development”* means services that assist individuals in preparing for, securing and maintaining gainful, competitive employment. Employment shall be integrated into normalized work settings, shall provide pay of at least minimum wage, and shall be based on the individual’s skills, preferences, abilities, and talents. Services assist individuals seeking employment to develop or re-establish skills, attitudes, personal characteristics, interpersonal skills, work behaviors, and functional capacities to achieve positive employment outcomes.

*“Medical assistance program”* means the same as defined in Iowa Code section 249A.2.

*“Medication management”* means services provided directly to or on behalf of the individual by a licensed professional as authorized by Iowa law including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care providers; investigating potentially negative or unintended psychopharmacologic or medical interactions; reviewing laboratory reports; and activities pursuant to licensed prescriber orders.

*“Medication prescribing”* means services with the individual present provided by an appropriately licensed professional as authorized by Iowa law including, but not limited to, determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.

*“Mental health outpatient therapy”* means the same as defined in Iowa Code section 230A.106(2)“a.”

*“Mental health professional”* means the same as defined in Iowa Code section 228.1(6).

*“Mobile response”* means the same as defined in rule 441—24.20(225C).

*“Multi-occurring conditions”* means a diagnosis of a severe and persistent mental illness occurring along with one or more of the following: a physical health condition, a substance use disorder, an intellectual or developmental disability, or a brain injury.

*“No reject, no eject”* means that an individual who otherwise meets the eligibility criteria for a service shall not be denied access to that service or discharged from that service based on the severity or complexity of that individual’s mental health and multi-occurring needs.

*“Peer support services”* means a program provided by a peer support specialist including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

*“Peer support specialist”* means an individual who has experienced a severe and persistent mental illness and who has successfully completed standardized training to provide peer support services through the medical assistance program or the Iowa Behavioral Health Care Plan.

*“Permanent supportive housing”* means voluntary, flexible supports to help individuals with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Tenants have access to an array of services that help them keep their housing, such as case management, assistance with daily activities, conflict resolution, and crisis response consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

*“Personal emergency response system”* means an electronic device connected to a 24-hour staffed system which allows the individual to access assistance in the event of an emergency.

*“Precariously housed”* means that a person does not have a permanent household and is living day-to-day in a motel, in a vehicle, with family or friends, or in some other temporary location.

*“Prescreening assessment”* means a face-to-face clinical interview to ascertain an individual’s current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition.

*“Prevocational services”* means services that focus on developing generalized skills that prepare an individual for employment. Prevocational training topics include but are not limited to attendance, safety skills, following directions, and staying on task.

*“Reasonably close proximity”* means a distance of 100 miles or less or a driving distance of two hours or less from the county seat or county seats of the region.

*“Region”* means a mental health and disability service region that operates as the “‘regional administrator’ or ‘regional administrative entity’” as defined in rule 441—25.11(331).

*“Respite services”* means a temporary period of relief and support for individuals and their families provided in a variety of settings. The intent is to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current issues related to a disability. Respite may be provided for a defined period of time; respite is either planned or provided in response to a crisis.

*“Routine care”* means the same as defined in rule 441—88.21(249A).

*“Rural”* means any area that is not defined as urban.

*“Severe and persistent mental illness”* or *“SPMI”* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that: (1) the individual does not have the resources or skills necessary to maintain function in the home or community environment without assistance or support; (2) the individual’s judgment, impulse control, or cognitive perceptual abilities are compromised; (3) the individual exhibits significant impairment in social, interpersonal, or familial functioning; and (4) the individual has a documented mental health diagnosis. For this purpose, a “mental health diagnosis” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other

conditions that may be a focus of clinical attention as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

*“Strengths-based case management”* means a service that focuses on possibilities rather than problems and strives to identify and develop strengths to assist individuals reach their goals leading to a healthy self-reliance and interdependence with their community. Identifiable strengths and resources include family, cultural, spiritual, and other types of social and community-based assets and networks.

*“Subacute mental health services”* means the same as defined in Iowa Code section 225C.6(4) “c” and includes both subacute facility-based services and subacute community-based services.

*“Substance use disorder”* means the same as defined in rule 641—155.1(125,135).

*“Supported community living services”* means services as defined in Iowa Code section 225C.21(1).

*“Supported employment”* means an approach to helping individuals participate as much as possible in competitive work in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals. Services are targeted for individuals with significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability including either individual or group supported employment, or both, consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

*“Telephone crisis service”* means a program that operates a crisis hotline either directly or through a contract. The service shall be available 24 hours a day and seven days a week including, but not limited to, relief of distress in pre-crisis and crisis situations, reduction of the risk of escalation, arrangements for emergency on-site responses when necessary, and referral of callers to appropriate services.

*“Trauma-focused services”* means services provided by caregivers and professionals that recognize when an individual who has been exposed to violence is in need of help to recover from adverse impacts; recognize and understand the impact that exposure to violence has on victims’ physical, psychological, and psychosocial development and well-being; and respond by helping in ways that reflect awareness of adverse impacts and consistently support the individual’s recovery.

*“Trauma-informed care”* means services that are based on an understanding of the vulnerabilities or triggers of those who have experienced violence, that recognize the role violence has played in the lives of those individuals, that are supportive of recovery, and that avoid retraumatization including trauma-focused services and trauma-specific treatment.

*“Trauma-specific treatment”* means services provided by a mental health professional using therapies that are free from the use of coercion, restraints, seclusion and isolation; and designed specifically to promote recovery from the adverse impacts of violence exposure on physical, psychological, psychosocial development, health and well-being.

*“Twenty-four-hour crisis response”* means the same as defined in rule 441—24.20(225C).

*“Twenty-three-hour observation and holding”* means the same as defined in rule 441—24.20(225C).

*“Urban”* means a county that has a total population of 50,000 or more residents or includes a city with a population of 20,000 or more.

*“Urgent nonemergency need”* means the same as defined in rule 441—88.21(249A).

*“Walk-in crisis service”* means a program that provides unscheduled face-to-face support and intervention at an identified location or locations. The service may be provided directly by the program or through a contract with another mental health provider.

*“Warm handoff”* means an approach to care transitions in which a health care provider uses face-to-face or telephone contact to directly link individuals being treated to other providers or specialists.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19]

#### **441—25.2(331) Core service domains.**

**25.2(1)** The region shall ensure that core service domains are available in regions as determined in Iowa Code section 331.397.

**25.2(2)** The region shall include and respect the recommendation of the individual and the individual's care team in the process of transition to new services.

**25.2(3)** The region shall ensure that the following services are available in the region:

- a. Access centers.
- b. Assertive community treatment.
- c. Assessment and evaluation.
- d. Case management.
- e. Crisis evaluation.
- f. Crisis stabilization community-based services.
- g. Crisis stabilization residential services.
- h. Day habilitation.
- i. Family support.
- j. Health homes.
- k. Home and vehicle modification.
- l. Home health aide.
- m. Intensive residential service homes.
- n. Job development.
- o. Medication prescribing and management.
- p. Mental health inpatient treatment.
- q. Mental health outpatient treatment.
- r. Mobile response.
- s. Peer support.
- t. Personal emergency response system.
- u. Prevocational services.
- v. Respite.
- w. Subacute mental health services.
- x. Supported employment.
- y. Supportive community living.
- z. Twenty-four-hour access to crisis response.
- aa. Twenty-three-hour crisis observation and holding.

Regions may fund or provide other services in addition to the required core services consistent with requirements set forth in subrules 25.2(4) and 25.2(5).

**25.2(4)** A regional service system shall consider the scope of services included in addition to the required core services. Each service included shall be described and projection of need and the funding necessary to meet the need shall be included.

**25.2(5)** A regional service system may provide funding for other appropriate services or support. In considering whether to provide such funding, a region may consider the following criteria:

- a. Applying a person-centered planning process to identify the need for the services or other support.
- b. The efficacy of the services or other support is recognized as an evidence-based practice, is deemed to be an emerging and promising practice, or providing the services is part of a demonstration and will supply evidence as to the effectiveness of the services.

c. A determination that the services or other support provides an effective alternative to existing services that have been shown by the evidence base to be ineffective, to not yield the desired outcome, or to not support the principles outlined in *Olmstead v. L.C.*, 527 U.S. 581.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19]

#### **441—25.3(331) Implementation dates.**

**25.3(1)** Regions shall implement the following core services effective July 1, 2014:

- a. Assessment and evaluation.
- b. Case management.
- c. Crisis evaluation.

- d. Day habilitation.
- e. Family support.
- f. Health homes.
- g. Home and vehicle modification.
- h. Home health aide.
- i. Job development.
- j. Medication prescribing and management.
- k. Mental health inpatient therapy.
- l. Mental health outpatient therapy.
- m. Peer support.
- n. Personal emergency response system.
- o. Prevocational services.
- p. Respite.
- q. Supported employment.
- r. Supportive community living.
- s. Twenty-four-hour access to crisis response.

**25.3(2)** Regions shall implement the following intensive mental health core services on or before July 1, 2021, provided that federal matching funds are available under the Iowa health and wellness plan pursuant to Iowa Code chapter 249N:

- a. Access centers.
- b. Assertive community treatment.
- c. Crisis stabilization community-based services.
- d. Crisis stabilization residential services.
- e. Intensive residential service homes.
- f. Mobile response.
- g. Subacute mental health services provided in facility and community-based settings.
- h. Twenty-three-hour crisis observation and holding.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.4(331) Access standards.** Regions shall meet the following access standards:

**25.4(1)** A sufficient provider network which shall include:

- a. A community mental health center or federally qualified health center that provides psychiatric and outpatient mental health services in the region.
- b. A hospital with an inpatient psychiatric unit or state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant.

**25.4(2)** Crisis services shall be available 24 hours per day, 7 days per week, 365 days per year for mental health and disability-related emergencies. A region may make arrangements with one or more other regions to meet the required access standards.

a. *Basic crisis response.*

(1) Twenty-four-hour crisis response. An individual shall have immediate access to crisis response services by means of telephone, electronic, or face-to-face communication.

(2) Crisis evaluation. An individual shall have immediate access to a crisis screening and will have a crisis assessment by a licensed mental health professional within 24 hours of referral.

b. *Crisis stabilization community-based services.* An individual who has been determined to need CSCBS shall receive face-to-face contact from the CSCBS provider within 120 minutes from the time of referral.

c. *Crisis stabilization residential services.* An individual who has been determined to need CSRS shall receive CSRS within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

d. *Mobile response.* An individual in need of mobile response services shall have face-to-face contact with mobile crisis staff within 60 minutes of dispatch.

*e. Twenty-three-hour observation and holding.* An individual who has been determined to need 23-hour observation and holding shall receive 23-hour observation and holding within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

**25.4(3)** The region shall provide the following treatment services:

*a. Outpatient.*

(1) Emergency: During an emergency, outpatient services shall be initiated to an individual within 15 minutes of telephone contact.

(2) Urgent: Outpatient services shall be provided to an individual within one hour of presentation or 24 hours of telephone contact.

(3) Routine: Outpatient services shall be provided to an individual within four weeks of request for appointment.

(4) Distance: Outpatient services shall be offered within 30 miles for an individual residing in an urban community and 45 miles for an individual residing in a rural community.

*b. Inpatient.*

(1) An individual in need of emergency inpatient services shall receive treatment within 24 hours.

(2) Inpatient services shall be available within reasonably close proximity to the region.

*c. Assessment and evaluation.* An individual who has received inpatient services shall be assessed and evaluated within four weeks.

**25.4(4)** Subacute facility-based mental health services. An individual shall receive subacute facility-based mental health services within 24 hours of referral. The service shall be located within 120 miles of the residence of the individual.

**25.4(5)** Support for community living. The first appointment shall occur within four weeks of the individual's request of support for community living.

**25.4(6)** Support for employment. The initial referral shall take place within 60 days of the individual's request of support for employment.

**25.4(7)** Recovery services. An individual receiving recovery services shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

**25.4(8)** Service coordination.

*a.* An individual receiving service coordination shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

*b.* An individual shall receive service coordination within ten days of the initial request for such service or being discharged from an inpatient facility.

**25.4(9)** The region shall make the following intensive mental health services available. A region may make arrangements with one or more other regions to meet the required access standards.

*a. Assertive community treatment.*

(1) A minimum of 22 ACT teams shall be operational statewide.

(2) A sufficient number of ACT teams shall be available to serve the number of individuals in the region who are eligible for ACT services. As a guideline for planning purposes, the ACT-eligible population is estimated to be about 0.06 percent of the adult population of the region. The region may identify multiple geographic areas within the region for ACT team coverage. Regions may work with one or more other regions to identify geographic areas for ACT team coverage.

*b. Access centers.*

(1) A minimum of six access centers shall be operational statewide.

(2) An access center shall be located within 120 miles of the residence of the individual or be available within 120 minutes from the time of the determination that the individual needs access center services.

*c. Intensive residential services.*

(1) A minimum of 120 intensive residential service beds shall be available statewide.

(2) An individual receiving intensive residential services shall have the service available within two hours of the individual's residence.

(3) An individual shall be admitted to intensive residential services within four weeks from referral.



**25.4(10)** The following limitations apply to home and vehicle modification for an individual receiving mental health and disability services:

*a.* A lifetime limit equal to that established for the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

*b.* A provider reimbursement payment will be no lower than that provided through the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.5(331) Practices.** A region shall ensure that access is available to providers of core services that demonstrate the following competencies:

**25.5(1)** Regions shall have service providers that are trained to provide effective services to individuals with multi-occurring conditions. Training for serving individuals with multi-occurring conditions provided by the region shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the regional service system management plan.

**25.5(2)** Regions shall have service providers that are trained to provide effective trauma-informed care. Trauma-informed care training provided by the region shall be recognized by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the regional service system management plan.

**25.5(3)** Regions must have evidence-based practices that the region has independently verified as meeting established fidelity to evidence-based service models including, but not limited to, assertive community treatment or strengths-based case management; integrated treatment of co-occurring substance use and mental health disorders; supported employment; family psychoeducation; illness management and recovery; and permanent supportive housing.

[ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.6(331) Intensive mental health services.** The purpose of intensive mental health services is to provide a continuum of services and supports to individuals with complex mental health and multi-occurring conditions who need a high level of intensive and specialized support to attain stability in health, housing, and employment and to work toward recovery.

**25.6(1) Access centers.** The purpose of an access center is to serve individuals experiencing a mental health or substance use crisis who are not in need of an inpatient psychiatric level of care and who do not have alternative, safe, effective services immediately available.

*a. Regional coordination.* Each region shall designate at least one access center provider and ensure that access center services are available to the residents of the region consistent with subrule 25.4(9).

(1) Regions shall work collaboratively to develop a minimum of six access centers strategically located throughout the state, with the support of the medical assistance program.

(2) Access centers may be shared by two or more regions.

(3) Each region shall establish methods to provide for reimbursement of a region when a non-Medicaid-eligible resident of another region utilizes an access center or other non-Medicaid-covered services located in that region.

*b. Access center standards.* A designated access center shall meet all of the following criteria:

(1) An access center shall have no residential facility-based setting with more than 16 beds.

(2) An access center provider shall be accredited to provide crisis stabilization residential services pursuant to 441—Chapter 24.

(3) An access center provider shall be licensed to provide subacute mental health services as described in rule 441—77.56(249A).

(4) An access center provider shall be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a cooperative agreement with and immediate access to licensed substance abuse treatment services or medical care that incorporates withdrawal management.

(5) An access center shall provide services on a no reject, no eject basis to individuals who meet service eligibility criteria.

(6) An access center shall accept and serve eligible individuals who are court-ordered to participate in mental health or substance use disorder treatment.

(7) An access center shall provide all required services listed in 25.6(1)“d” in a coordinated manner. An access center may provide coordinated services in one or more locations.

*c. Eligibility for access center services.* To be eligible to receive access center services, an individual shall meet all of the following criteria:

(1) The individual is in need of screening, assessment, services or treatment related to a mental health or substance use crisis.

(2) The individual shows no obvious signs of illness or injury indicating a need for immediate medical attention.

(3) The individual has been determined not to need an inpatient psychiatric hospital level of care.

(4) The individual does not have immediate access to alternative, safe, and effective services.

*d. Access center services.* An access center shall provide or arrange for the provision of all of the following:

(1) Immediate intake assessment and screening that includes but is not limited to mental and physical health conditions, suicide risk, brain injury, and substance use. A crisis evaluation that includes all required screenings may serve as an intake assessment.

(2) Comprehensive person-centered mental health assessments by appropriately licensed or credentialed professionals, as indicated by the intake assessment.

(3) Comprehensive person-centered substance use disorder assessments by appropriately licensed or credentialed professionals, as indicated by the intake assessment.

(4) Peer support services, as indicated by a comprehensive assessment.

(5) Mental health treatment, as indicated by a comprehensive assessment.

(6) Substance use treatment, as indicated by a comprehensive assessment.

(7) Physical health care services as indicated by a health screening.

(8) Care coordination.

(9) Service navigation and linkage to needed services including housing, employment, shelter services, intellectual and developmental disability services, and brain injury services, with warm handoffs to other service providers.

**25.6(2) Assertive community treatment (ACT) services.** The purpose of assertive community treatment is to serve individuals with the most severe and persistent mental illness conditions and functional impairments. ACT services provide a set of comprehensive, integrated, intensive outpatient services delivered by a multidisciplinary team under the supervision of a psychiatrist, an advanced registered nurse practitioner, or a physician assistant under the supervision of a psychiatrist. An ACT program shall designate an individual to be responsible for administration of the program and with the authority to sign documents and receive payments on behalf of the program.

*a. Regional coordination.* Each region shall designate at least one ACT provider and ensure that ACT services are available to the residents of the region consistent with subrule 25.4(9). Regions may work collaboratively with other regions when an ACT team is serving more than one region.

(1) Each region shall determine the number and size of ACT teams needed to serve the ACT-eligible population in that region.

(2) Each region shall verify that all ACT programs operating in the region have periodic fidelity reviews consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration (SAMHSA). Each ACT program shall have a fidelity review, including a peer review, on the following schedule:

1. Within the first 12 months of operation.

2. Annually during each of the second and third years of operation.

3. Biennially thereafter for teams with satisfactory fidelity reviews. Teams with unsatisfactory reviews shall be reviewed again after one year.

Results of the ACT team fidelity reviews shall be included in the region’s annual report.

*b. ACT team composition.* Each ACT team shall include a minimum of six members and must include a member qualified to fill each of the eight following roles. One team member may fill more than one role if all other qualifications are met.

(1) A psychiatrist, an advanced registered nurse practitioner, or a physician assistant under the supervision of a psychiatrist who is board-certified or eligible for board certification.

(2) A team leader.

(3) A registered nurse.

(4) A mental health professional.

(5) A substance abuse treatment provider.

(6) A community support specialist.

(7) A peer support specialist.

(8) An employment specialist.

*c. Staff qualifications.* ACT team members shall meet the following qualifications:

(1) Psychiatrist. A psychiatrist on the team shall be a person who meets all of the following criteria:

1. Is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).

2. Is licensed in Iowa pursuant to 653—Chapter 9.

3. Is certified or is eligible to be certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry.

4. Has experience working with persons with severe and persistent mental illness.

5. Provides a minimum of 16 hours per week of psychiatrist time for every 50 ACT clients.

(2) Advanced registered nurse practitioner. An advanced registered nurse practitioner on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 655—Chapter 7.

2. Has a mental health certification.

3. Has experience working with persons with severe and persistent mental illness.

4. Provides a minimum of 16 hours per week of advanced registered nurse practitioner time for every 50 ACT clients.

(3) Physician assistant. A physician assistant on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 645—Chapter 326.

2. Has experience working with persons with severe and persistent mental illness.

3. Is practicing under the supervision of a psychiatrist who is board-certified or eligible for board certification.

4. Provides a minimum of 16 hours per week of physician assistant time for every 50 ACT clients.

(4) Team leader. A team leader shall be a person on the team who meets all of the following criteria:

1. Has a master's degree in a mental health field, including but not limited to nursing, social work, mental health counseling, psychiatric rehabilitation, or psychology.

2. Is actively involved in direct contact with individuals being served by the team.

3. Is a full-time staff member whose responsibilities are limited to the ACT team and who serves as the clinical and administrative supervisor of the team.

(5) Registered nurse. A registered nurse on the team shall be a person who meets all of the following criteria:

1. Is licensed as a registered nurse pursuant to 655—Chapter 3.

2. Has experience working with persons with severe and persistent mental illness.

(6) Mental health professional. A mental health professional on the team shall be a person who meets all of the following criteria:

1. Is a mental health counselor or marital and family therapist licensed pursuant to 645—Chapter 31; a social worker licensed as a master or independent social worker pursuant to 645—Chapter 280; or an occupational therapist licensed pursuant to 645—Chapter 206.

2. Has experience working with persons with severe and persistent mental illness.

(7) Substance abuse treatment professional. A substance abuse treatment professional on the team shall be a person who meets all of the following criteria:

1. Is an appropriately credentialed counselor pursuant to 641—subparagraph 155.21(8) “b”(1).
2. Has at least three years of experience working with persons with substance use disorders.

(8) Community support specialist. A community support specialist on the team shall be a person who meets all of the following criteria:

1. Has a bachelor’s degree with at least 30 semester hours or equivalent quarter hours in a human services field, including but not limited to sociology, social work, counseling, psychology, or human services.

2. Has experience working with persons with severe and persistent mental illness.

(9) Peer support specialist. A peer support specialist on the team shall be a person who meets all of the following criteria:

1. Has been diagnosed with a severe and persistent mental illness.

2. Has met all requirements of the Appalachian Consulting Group Peer Support Training Model by no later than six months after the date of hire.

(10) Employment specialist. An employment specialist on the team shall be a person who meets all of the following criteria:

1. Has experience working with persons with severe and persistent mental illness.
2. Meets one of the following:
  - Has a bachelor’s degree with at least 30 semester hours or equivalent quarter hours in a human services field, including but not limited to sociology, social work, counseling, or psychology, and completes at least 12 hours of employment services training within six months of the date of hire.
  - Has a high school diploma or equivalent, has at least one year of specialized vocational training or supervised experience in vocational and related services, including but not limited to supported employment, job coaching, supported community living, or habilitation, and completes at least 12 hours of employment services training within six months of the date of hire.

(11) Psychologist. A psychologist on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 645—Chapter 240.
2. Has experience working with persons with a severe and persistent mental illness.

*d. ACT provider standards.* Organizations seeking regional designation as an ACT provider shall meet the following criteria at initial application and annually thereafter. A designated ACT provider shall:

(1) Develop and maintain written ACT-specific admission policies and procedures, including but not limited to a gradual rate of admission and program eligibility requirements.

(2) Develop and maintain written ACT-specific discharge policies and procedures. Discharge criteria shall include but are not limited to the following:

1. An individual reaches individually established goals for discharge, and the individual and program staff mutually agree to the termination of services; or

2. An individual requests discharge, demonstrates the ability to function in all major role areas without ongoing assistance from the program and without significant relapse when services are withdrawn, and the program staff agree to the termination of services; or

3. An individual moves outside the geographic area of the team’s responsibility. In such cases, the team shall arrange for transfer of responsibility for mental health services to an ACT program or another provider wherever the individual is relocating, and the team shall maintain contact with the individual until the service transfer is implemented; or

4. An individual declines or refuses services and requests discharge despite the team’s best efforts to develop an acceptable treatment plan with the individual.

(3) Documentation of discharges. Documentation shall include:

1. The reason(s) for discharge as stated by both the individual and the team.
2. A summary of the individual’s biopsychosocial status at the time of discharge.

3. A written final evaluation summary of the individual's progress toward the goals in the treatment plan.
  4. A plan developed in conjunction with the individual for follow-up treatment after discharge.
  5. The signature of each of the following:
    - The individual, or documentation of why the individual's signature was not obtained.
    - The service coordinator.
    - The team leader.
    - The psychiatrist, advanced registered nurse practitioner, or physician assistant under the supervision of a board-certified psychiatrist.
- e. ACT team standards.* All designated ACT teams shall:
- (1) Participate in all of the individual's mental health services.
  - (2) Ensure that services for the psychiatric needs of the individual are available 24 hours a day.
  - (3) Develop a specific treatment plan based on the assessment of needs and including goals and actions to address the individual's medical, social, educational, and other needs.
  - (4) Make referrals to services and related activities to assist the individual with the individual's assessed needs.
  - (5) Monitor and perform follow-up activities necessary to ensure that the treatment plan is carried out and that the individual has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
  - (6) Hold team meetings at least four times a week to facilitate ACT services and briefly review the status of the individual with other members of the team.
  - (7) Have the capacity to provide multiple contacts a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in a living situation or employment, or having significant ongoing problems in daily living. All members of the team share responsibility for addressing the needs of all individuals. The number of team contacts per individual served shall average at least three per week per individual when calculated across all individuals served by the team. Contacts may be weekly, daily, or more frequent. The frequency of contacts is determined by the needs of the individual.
  - (8) Have the capacity to rapidly increase service intensity to an individual when the individual's status requires it or the individual requests it.
  - (9) Ensure that treatment, rehabilitation, and support activities are available 24 hours a day, 7 days a week, 365 days a year, including nights, weekends, and holidays. If there are insufficient numbers of staff to operate an after-hours on-call system, staff shall provide crisis response during regular work hours and arrange coverage for all other hours through a reliable crisis response service.
  - (10) Provide no more than 20 percent of service contacts in office-based settings.
- f. Staff-to-client ratio.* ACT teams shall maintain a ratio of at least one full-time or full-time equivalent staff person to every ten individuals served. The ACT team staff-to-client ratios do not include the psychiatrist, advanced nurse practitioner, or physician assistant practicing under the supervision of a psychiatrist.
- g. Eligibility criteria for ACT services.* To be eligible to receive ACT services, the individual shall meet all of the following criteria:
- (1) Is at least 17 years of age.
  - (2) Has a severe and persistent mental illness or complex mental health symptomology. Individuals with a primary diagnosis of substance use disorder, developmental disability, personality disorder, or organic disorder are not eligible for ACT services.
  - (3) Is in need of a consistent team of professionals and multiple mental health and support services to live independently in the community and reduce hospitalizations, as evidenced by one or both of the following:
    1. A pattern of repeated treatment failures during the previous 12 months, including at least two psychiatric hospitalizations or psychiatric care delivered at least twice in an emergency department, at an access center, or by a mobile crisis team; or

2. The need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

(4) Presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the individual's functioning and assist the individual in achieving or maintaining independent community living. Specifically, the individual:

1. Is medically stable;
2. Does not require a level of care that includes more intensive medical monitoring;
3. Presents a low risk to self, others, or property, with treatment and support; and
4. Lives independently in the community or demonstrates a capacity and desire to live independently in the community.

*h. ACT services.* ACT teams shall provide the following services:

(1) Initial assessment and treatment planning.

1. An assessment of the individual shall be completed within 30 days of admission that includes psychiatric history, medical history, educational history, employment, substance use, problems with activities of daily living, social interests, and family relationships.

2. An individualized written treatment plan shall be developed based on the assessment. The treatment plan shall identify the necessary psychiatric rehabilitation treatment and support services, including all of the following:

- Treatment objectives and outcomes.
- The expected frequency and duration of each service.
- The location where the services will be provided.
- A crisis plan.
- The schedule for updates of the treatment plan.

(2) Evaluation and medication management.

1. The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the individual by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

2. Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant in response to the individual's complaints and symptoms. A psychiatric registered nurse assists in this management by making contact with the individual regarding medications and their effect on the individual's complaints and symptoms.

(3) Integrated therapy and counseling for mental health and substance abuse. Integrated therapy and counseling consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling may be provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

(4) Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by any team member.

(5) Community support. Community support may be provided by any team member and consists of the following activities focused on recovery and rehabilitation:

1. Personal and home skills training to assist the individual to develop and maintain skills for self-direction and coping with the living situation.

2. Community skills training to assist the individual in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

(6) Medication monitoring. Medication monitoring services shall be provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consists of:

1. Monitoring the individual's day-to-day functioning, medication compliance, and access to medications; and

2. Ensuring that the individual keeps appointments.

(7) Case management for treatment and service plan coordination. Case management consists of the development of an individualized treatment and service plan, including personalized goals and

outcomes, to address the individual's medical symptoms and remedial functional impairments. Case management includes:

1. Assessments, referrals, follow-up, and monitoring.
2. Assisting the individual in gaining access to necessary medical, social, educational, and other services.

3. Assessing the individual to determine service needs by collecting relevant historical information through records and other information from relevant professionals and natural supports.

(8) Crisis response. Crisis response consists of direct assessment and treatment of the individual's urgent or crisis symptoms in the community by any team member, as appropriate.

(9) Work-related services. Work-related services may be provided by any team member. Services consist of assisting the individual in managing mental health symptoms as they relate to job performance and may include:

1. Collaborating with the individual to look for job situations of the individual's choice and creating strategies to manage situations that cause symptoms to increase.

2. Assisting the individual to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

3. Providing supports to maintain employment, such as crisis intervention related to employment.

4. Teaching communication, problem-solving, and safety skills.

5. Teaching personal skills, such as time management and appropriate grooming for employment.

(10) Peer support services. Peer support services are provided by a peer support specialist and include, but are not limited to, education and information, individual advocacy, and crisis response.

(11) Support services. All team members are responsible for providing support services. Services consist of assisting the individual in obtaining the basic necessities of daily life, including but not limited to:

1. Medical and dental services.

2. Safe, clean, and affordable housing.

3. Financial support.

4. Benefits counseling.

5. Social services.

6. Transportation.

7. Legal advocacy and representation.

(12) Education, support, and consultation to family members and other major supports of individuals. All team members are responsible for providing education, support, and consultation to family members and other major supports of individuals with the agreement or consent of the individual. Services include but are not limited to:

1. Individualized psychoeducation about the individual's illness and the role of the family and other significant people in the therapeutic process.

2. Intervention to restore contact, resolve conflicts, and maintain relationships with family or other significant people or both.

3. Ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family.

4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

5. Assistance to obtain necessary services for individuals with children, including but not limited to:

- Individual supportive counseling.

- Parenting training.

- Service coordination.

- Services to help the individual throughout pregnancy and the birth of a child.

- Services to help the individual fulfill parenting responsibilities and coordinate services for the child or children.

- Services to help the individual restore relationships with children who are not in the individual's custody.

**25.6(3) Mobile response.** The purpose of mobile response is to provide short-term individualized crisis stabilization, following a crisis screening or assessment, that is designed to restore the individual to a prior functional level. Mobile response services shall be provided as described in rule 441—24.36(225C).

**25.6(4) 23-hour observation and holding.** The purpose of 23-hour observation and holding is to provide up to 23 hours of care in a safe and secure, medically staffed treatment environment. Twenty-three-hour observation and holding shall be provided as described in rule 441—24.37(225C).

**25.6(5) Crisis stabilization community-based services.** The purpose of crisis stabilization community-based services is to provide short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in the setting where the individual lives, works, or recreates. Crisis stabilization community-based services shall be provided as described in rule 441—24.38(225C).

**25.6(6) Crisis stabilization residential services.** The purpose of crisis stabilization residential services is to provide a short-term alternative living arrangement in a setting of no more than 16 beds that is designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis. Crisis stabilization residential services shall be provided as described in rule 441—24.39(225C).

**25.6(7) Subacute mental health services.** The purpose of subacute mental health services is to provide a comprehensive set of wraparound services to individuals who have had or are at imminent risk of having acute or crisis mental health symptoms.

*a. Regional coordination.* Each region shall designate at least one subacute mental health service provider and ensure that subacute mental health services are available to the residents of the region consistent with subrule 25.4(4).

*b. Subacute mental health services standards.*

(1) Subacute mental health services in a facility-based setting shall be provided as described in Iowa Code chapter 135G and 481—Chapter 71.

(2) Subacute mental health services in a community-based setting are the same as assertive community treatment (ACT) services provided as described in subrule 25.6(2).

**25.6(8) Intensive residential services.** The purpose of intensive residential services is to serve individuals with the most intensive severe and persistent mental illness conditions who have functional impairments and may also have multi-occurring conditions. Intensive residential services provide intensive 24-hour supervision, behavioral health services, and other supportive services in a community-based residential setting.

*a. Regional coordination.* Each region shall designate at least one intensive residential services provider and ensure that intensive residential services are available to the residents of the region consistent with subrule 25.4(9).

(1) Regions shall work collaboratively to develop intensive residential services strategically located throughout the state with the capacity to serve a minimum of 120 individuals, with the support of the medical assistance program.

(2) Intensive residential services may be shared by two or more regions.

(3) Each region shall establish methods to provide for reimbursement of a region when the non-Medicaid-eligible resident of another region utilizes intensive residential services or other non-Medicaid-covered services located in that region.

*b. Intensive residential services standards.* An organization that seeks regional designation as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A designated intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) habilitation provider or an HCBS 1915(c) intellectual disability waiver supported community living provider in good standing with the Iowa Medicaid enterprise.

(2) Provide staffing 24 hours a day, 7 days a week, 365 days a year.

(3) Maintain a minimum staffing ratio of one staff to every two and one-half residents. Staffing ratios shall be responsive to the needs of the individuals served.



- (4) Ensure that all staff members have the following minimum qualifications:
    1. One year of experience working with individuals with a mental illness or multi-occurring conditions.
    2. A high school diploma or equivalent.
  - (5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:
    1. Applied behavioral analysis.
    2. Autism spectrum disorders, diagnoses, symptomology and treatment.
    3. Brain injury diagnoses, symptomology and treatment.
    4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.
    5. Motivational interviewing.
    6. Psychiatric medications.
    7. Substance use disorders and treatment.
    8. Other diagnoses or conditions present in the population served.
  - (6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.
  - (7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.
  - (8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services, including but not limited to ACT.
  - (9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.
  - (10) Accept and serve eligible individuals who are court-ordered to intensive residential services.
  - (11) Provide services to eligible individuals on a no reject, no eject basis.
  - (12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site.
  - (13) Be located in a neighborhood setting to maximize community integration and natural supports.
  - (14) Demonstrate specialization in serving individuals with an SPMI or multi-occurring conditions and serve individuals with similar conditions in the same site.
- c. Eligibility criteria for admission to intensive residential services.* To be eligible to receive intensive residential services, an individual shall meet all of the following criteria:
- (1) The individual is an adult with a diagnosis of a severe and persistent mental illness or multi-occurring conditions.
  - (2) The individual is approved by the Iowa Medicaid enterprise or Medicaid managed care organization, as appropriate, for the highest rate of home-based habilitation or the highest rate of home- and community-based services intellectual disability waiver supported community living service. Reimbursement rates for intensive residential services shall be equal to or greater than the established fees for those services. Regional reimbursement rates for non-Medicaid individuals receiving intensive residential services shall be negotiated by the region and the provider and shall be no less than the minimum Medicaid rate.
  - (3) The individual has had a standardized functional assessment and screening for multi-occurring conditions completed 30 days or less prior to application for intensive residential services, and the functional assessment and screening demonstrates that the individual:
    1. Has a diagnosis that meets the criteria of severe and persistent mental illness as defined in rule 441—25.1(331);

2. Has three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;
3. Is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;
4. Has exhibited a lack of progress or regression after an adequate trial of active treatment at a less intensive level of care;
5. Is at risk of significant functional deterioration if intensive residential services are not received or continued; and
6. Meets one or more of the following:
  - Has a record of three or more psychiatric hospitalizations in the 12 months preceding application for intensive residential services.
  - Has a record of more than 30 medically unnecessary psychiatric hospital days in the 12 months preceding application for intensive residential services.
  - Has a record of more than 90 psychiatric hospital days in the 12 months preceding application for intensive residential services.
  - Has a record of three or more emergency room visits related to a psychiatric diagnosis in the 12 months preceding application for intensive residential services.
  - Is residing in a state resource center and has an SPMI.
  - Is being served out of state due to the unavailability of medically necessary services in Iowa.
  - Has an SPMI and is scheduled for release from a correctional facility or a county jail.
  - Is homeless or precariously housed.

[ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.7(331) Non-core services.** When a mental health and disability services region chooses to make the following non-core services available, the region shall ensure that such services meet the requirements of this rule.

**25.7(1) Prescreening assessments.** Prescreening assessments provided by the region or an entity contracting with the region shall meet the following requirements:

*a.* The prescreening assessment shall be provided in an emergency room or other crisis assessment setting within four hours of an emergency detention of an individual believed to be mentally ill to determine if inpatient psychiatric hospitalization is necessary.

*b.* The prescreening assessment shall be performed by a licensed physician or mental health professional who shall also provide ongoing consultations while the individual remains in the emergency room or other crisis assessment setting. The services provided by the consulting professional are intended to supplement, but do not replace, the services of the emergency room or other crisis setting staff.

*c.* The licensed physician or mental health professional shall submit appropriate documentation and reports to the emergency room or other crisis setting and the court as necessary.

*d.* The region or entity contracting with the region shall ensure the coordination of appropriate levels of care. Coordination may include but is not limited to:

- (1) Securing an inpatient psychiatric bed when inpatient psychiatric hospitalization is needed.
- (2) Utilizing community-based resources and services such as 23-hour observation and holding, crisis stabilization community-based or residential services, subacute facility-based mental health services or detoxification centers.
- (3) Facilitating outpatient treatment appointments when inpatient psychiatric hospitalization is not needed.

**25.7(2) Transportation.** A service provider that is under contract with a region and transports individuals pursuant to an Iowa Code chapter 229 court order shall meet the following requirements:

*a.* The transport vehicle shall be secure such that the individual being transported cannot open doors or windows of the vehicle while it is moving.

b. Transportation staff shall complete a minimum of eight hours of training in mental health issues and crisis intervention in the first month of employment. After the initial training, each staff member shall complete a minimum of two hours of training annually.

These rules are intended to implement Iowa Code chapter 331 and 2018 Iowa Acts, House File 2456. [ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.8 to 25.10** Reserved.

DIVISION II  
REGIONAL SERVICE SYSTEM

PREAMBLE

These rules define the standards for a regional service system. The mental health and disability services provided by counties operating as a region shall be delivered in accordance with a regional service system management plan approved by the region's governing board and implemented by the regional administrator (Iowa Code section 331.393). Iowa counties are encouraged to enter into a regional system when the regional approach is likely to increase the availability of services to residents of the state who need the services. It is the intent of the Iowa general assembly that the adult residents of this state should have access to needed mental health and disability services regardless of the location of their residence.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.11(331) Definitions.**

*“Access point”* means a provider, public or private institution, advocacy organization, legal representative, or educational institution with staff trained to complete applications and guide individuals with a disability to needed services.

*“Applicant”* means an individual who applies to receive services and supports from the service system.

*“Assessment and evaluation”* means the same as defined in rule 441—25.1(331).

*“Assistive technology account”* means funds in contracts, savings, trust or other financial accounts, financial instruments, or other arrangements with a definite cash value that are set aside and designated for the purchase, lease, or acquisition of assistive technology, assistive technology services, or assistive technology devices. Assistive technology accounts must be held separately from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology services or devices for a working individual with a disability. Any withdrawal from an assistive technology account other than for the designated purpose becomes a countable resource.

*“Authorized representative”* means a person designated by the individual or by Iowa law to act on the individual's behalf in specified affairs to the extent prescribed by law.

*“Chief executive officer”* means the person chosen and supervised by the governing board who serves as the single point of accountability for the mental health and disability services region and whose responsibilities include, but are not limited to, planning, budgeting, monitoring county and regional expenditures, and ensuring the delivery of quality services that achieve expected outcomes for the individuals served.

*“Choice”* means the individual or authorized representative chooses the services, supports, and goods needed to best meet the individual's goals and accepts the responsibility and consequences of those choices.

*“Clear lines of accountability”* means the structure of the governing board's organization makes it evident that the ultimate responsibility for the administration of the non-Medicaid-funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization's chief executive officer.

*“Community”* means an integrated setting of an individual's choice.

*“Conflict-free case management”* means there is no real or seeming incompatibility between the case manager's other interests and the case manager's duties to the individual served and includes case

management separate from direct service provision; eligibility determination for services; establishment of funding levels for the individual's services; and requirements that prohibit the case manager from performing evaluations, assessments, and plans of care if the case manager is related by blood or marriage to the individual or any of the individual's paid caregivers or persons financially responsible for the individual or empowered to make financial or health-related decisions on behalf of the individual.

*"Coordinator of disability services"* means the same as defined in Iowa Code section 331.390(3) "b."

*"Countable resource"* means real or personal property that has a cash value that is available to the owner upon disposition and is capable of being liquidated.

*"Countable value"* means the equity value of a resource, which is the current fair market value minus any legal debt on the item.

*"County of residence"* means the same as defined in Iowa Code section 331.394.

*"Department"* means the department of human services.

*"Director"* means the director of human services.

*"Disability services"* means the same as defined in Iowa Code section 225C.2.

*"Emergency service"* means the same as defined in rule 441—88.21(249A).

*"Empowerment"* means that the service system ensures the rights, dignity, and ability of individuals and their families to exercise choices, take risks, provide input, and accept responsibility.

*"Exempt resource"* means a resource that is disregarded in the determination of eligibility for public funding assistance and in the calculation of client participation amounts.

*"Homeless person"* means the same as defined in Iowa Code section 48A.2.

*"Household"* means, for an individual who is 18 years of age or over, the individual, the individual's spouse or domestic partner, and any children, stepchildren, or wards under the age of 18 who reside with the individual. For an individual under the age of 18, "household" means the individual, the individual's parents (or parent and domestic partner), stepparents or guardians, and any children, stepchildren, or wards under the age of 18 of the individual's parents (or parent and domestic partner), stepparents, or guardians who reside with the individual.

*"Income"* means all gross income received by the individual's household, including but not limited to wages, income from self-employment, retirement benefits, disability benefits, dividends, annuities, public assistance, unemployment compensation, alimony, child support, investment income, rental income, and income from trust funds.

*"Individual"* means any person seeking or receiving services in a regional service system.

*"Individualized services"* means services and supports that are tailored to meet the personalized needs of the individual.

*"Liquid assets"* means assets that can be converted to cash in 20 days. Liquid assets include but are not limited to cash on hand, checking accounts, savings accounts, stocks, bonds, cash value of life insurance, individual retirement accounts, certificates of deposit, and other investments.

*"Managed care"* means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors: achieving high-quality outcomes for participants, coordinating access, and containing costs.

*"Managed system"* means a system that integrates planning, administration, financing, and service delivery. The system consists of the financing or governing organization, the entity responsible for care management, and the network of service providers.

*"Management organization"* means an organization contracted to manage part or all of the service system for a region.

*"Medical savings account"* means an account that is exempt from federal income taxation pursuant to Section 220 of the U.S. Internal Revenue Code (26 U.S.C. §220) as supported by documentation provided by the bank or other financial institution. Any withdrawal from a medical savings account other than for the designated purpose becomes a countable resource.

*"Mental health professional"* means the same as defined in Iowa Code section 228.1(6).

“*Non-liquid assets*” means assets that cannot be converted to cash in 20 days. Non-liquid assets include, but are not limited to, real estate, motor vehicles, motor vessels, livestock, tools, machinery, and personal property.

“*Population*” means the same as defined in Iowa Code section 331.388.

“*Provider*” means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance, is accredited under 441—Chapter 24, holds a professional license to provide the service, is accredited by a national insurance panel, or holds other national accreditation or certification.

“*Regional administrator*” or “*regional administrative entity*” means the administrative office or organization formed by agreement of the counties participating in a mental health and disability services region to function on behalf of those counties.

“*Regional services fund*” means the mental health and disability regional services fund created in Iowa Code section 225C.7A.

“*Regional service system management plan*” means the regional service system plan developed pursuant to Iowa Code section 331.393 for the funding and administration of non-Medicaid-funded mental health and disability services and includes an annual service and budget plan, a policies and procedures manual, and an annual report and how the region will coordinate with the department in the provision of mental health and disability services funded under the medical assistance program.

“*Resources*” means all liquid and non-liquid assets that are owned in part or in whole by the individual household, that could be converted to cash to use for support and maintenance, and that the individual household is not legally restricted from using for support and maintenance.

“*Retirement account*” means any retirement or pension fund or account listed in Iowa Code section 627.6(8)“f.”

“*Retirement account in the accumulation stage*” means a retirement account into which a deposit was made in the previous tax year. Any withdrawal from a retirement account becomes a countable resource.

“*Service system*” refers to the mental health and disability services and supports administered by the regional administrative entity and paid from the regional services fund.

“*State case status*” means the standing of an individual who has no county of residence.

“*State commission*” means the same as defined in Iowa Code section 225C.5.

“*System of care*” means the coordination of a system of services and supports to individuals and their families that ensures they optimally live, work, and recreate in integrated communities of their choice.

“*System principles*” means practices that include individual choice, community and empowerment. [ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.12(331) Regional governance structure.** The counties comprising a mental health and disability services region shall enter into an agreement to form a regional administrator under the control of a governing board to function on behalf of those counties as defined in Iowa Code chapter 28E and sections 331.388, 331.390 and 331.392 and 2013 Iowa Acts, House File 648, section 14.

**25.12(1) Governing board.** The governing board shall comply with the following requirements:

*a.* The governing board shall comply with the membership requirements as outlined in Iowa Code section 331.390 and follow the requirements in Iowa Code chapter 69 and other applicable laws relating to boards and commissions.

*b.* A regional advisory committee shall be created and shall designate members to the governing board as defined in Iowa Code section 331.390(2).

*c.* The governing board shall appoint and evaluate the performance of the chief executive officer of the regional administrative entity who will serve as the single point of accountability for the region.

**25.12(2) Regional administrator.** The formation of the regional administrator shall be as defined in Iowa Code sections 331.388 and 331.390.

*a.* The regional administrative entity is under the control of the governing board.

*b.* The regional administrative entity shall enter into and manage performance-based contracts in accordance with Iowa Code section 225C.4(1)“u.”

- c. The regional administrative entity structure shall have clear lines of accountability.
- d. The regional administrative entity functions as a lead agency utilizing shared county or regional staff or other means of limiting administrative costs.
- e. The regional administrative entity staff shall include one or more coordinators of disability services.

**25.12(3) Regional service system management.** The region may either directly implement a system of service management and contract with service providers, or contract with a private entity to manage the regional service system, provided all requirements of Iowa Code section 331.393 are met by the private entity.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.13(331) Regional finances.**

**25.13(1) Funding.** Non-Medicaid mental health and disability services funding is under the control of the governing board and shall:

- a. Be maintained to limit administrative burden and provide public transparency regarding financial processes.
- b. Be maintained in one of three ways:
  - (1) In a combined account.
  - (2) In separate county accounts that are under the control of the governing board.
  - (3) In other arrangements authorized by law.

**25.13(2) Accounting system and financial reporting.** The accounting system and financial reporting to the department shall conform to Iowa Code section 331.391 and include all non-Medicaid mental health and disability expenditures. Information shall be separated and identified in a uniform chart of accounts, including but not limited to the following: expenses for administration; purchase of services; and enterprise costs for which the region is a service provider or is directly billing and collecting payments.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.14(331) Regional governance agreement.** The expectations for regional governance agreements entered into by the counties comprising a mental health and disability services region are defined in Iowa Code sections 28E.1, 331.388, 331.390 and 331.392.

**25.14(1) Organizational provisions.** The organizational provisions of the regional governance agreement shall include the following:

- a. A statement of purpose, goals, and objective of entering into the agreement.
- b. Identification of the governing board membership and the terms, methods of appointment, and voting procedures, including whether or not voting will be weighted.
- c. The identification of the process for selecting the executive staff, including but not limited to the chief executive officer of the regional administrative entity.
- d. Identification of the counties participating in the agreement.
- e. The time period of the agreement and terms for termination or renewal of the agreement.
- f. Provisions for joining a region. Additional counties may join the region. The agreement shall not prohibit a county from being assigned by the department to a region according to Iowa Code section 331.389(4)“c.”
- g. Methods for dispute resolution and mediation.
- h. Methods for termination of a county’s participation in the region.
- i. Provision for formation and assigned responsibilities for one or more advisory committees consisting of:
  - (1) Individuals who utilize services or the actively involved relatives of such individuals.
  - (2) Service providers.
  - (3) Governing board members.
  - (4) Other interests identified in the agreement.

**25.14(2) Administrative provisions.** The administrative provisions of the regional governance agreement shall include all of the following:

a. Identification of whether the region will either directly implement a system of service management or contract with a private entity to manage the regional service system as defined in Iowa Code section 331.393(7).

b. Responsibility of the governing board in appointing and evaluating the performance of the chief executive officer of the regional administrative entity.

c. A general list of the functions and responsibilities of the regional administrative entity's chief executive officer and other staff including but not limited to coordinators of disability services.

d. Specification of the functions to be carried out by each party to the agreement and by any subcontractor of a party to the agreement.

**25.14(3) *Financial provisions.*** The financial provisions of the regional governance agreement shall include all of the following:

a. Methods for pooling, managing and expending funds under control of the regional administrative entity. If the agreement does not provide for pooling of the participating county moneys in a single fund, the agreement shall specify how the participating county moneys will be subject to the control of the regional administrative entity.

b. Methods for allocating administrative funding and resources.

c. Methods for contributing initial funds to the region.

d. Methods for acquiring or disposing of real property.

e. The process for how to use savings achieved for reinvestment.

f. A process for performance of an annual independent audit of the regional administrator.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.15(331) Eligibility, diagnosis, and functional assessment criteria.**

**25.15(1) *Eligibility for mental health services.*** An individual must comply with all of the following requirements to be eligible for mental health services under the regional service system:

a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has had at any time during the preceding 12-month period a mental health, behavioral, or emotional disorder or, in the opinion of a mental health professional, may now have such a diagnosable disorder. The diagnosis shall be made in accordance with the criteria provided in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and shall not include the manual's "V" codes identifying conditions other than a disease or injury. The diagnosis shall also not include substance-related disorders, dementia, antisocial personality, or developmental disabilities, unless co-occurring with another diagnosable mental illness.

e. The results of a standardized functional assessment support the need for mental health services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for mental health services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

**25.15(2) *Other conditions of eligibility for mental health services.***

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those mental health services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to

availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

**25.15(3) Eligibility for intellectual disability services.** An individual must comply with all of the following requirements to be eligible for intellectual disability services under the regional service system:

- a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- b. The individual is at least 18 years of age.
- c. The individual is a resident of this state.
- d. The individual has a diagnosis of intellectual disability as defined by Iowa Code section 4.1(9A).
- e. The results of a standardized functional assessment support the need for intellectual disability services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for intellectual services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

**25.15(4) Other conditions of eligibility for intellectual disability services.**

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those intellectual disability services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

**25.15(5) Eligibility for brain injury services.** An individual must comply with all of the following requirements to be eligible for brain injury services under the regional service system, if such services were provided to the same class of individuals by a county in the region prior to regional formation.

- a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- b. The individual is at least 18 years of age.
- c. The individual is a resident of this state.
- d. The individual has a diagnosis of brain injury as defined in rule 441—83.81(249A).
- e. The results of a standardized functional assessment support the need for brain injury services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology used is the methodology approved for brain injury services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

**25.15(6) Other conditions of eligibility for brain injury services.** An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

**25.15(7) Eligibility for developmental disability services.**

a. Until funding is designated for other service populations, eligibility for the core service domains shall be as identified in Iowa Code section 331.397(1) "b."

b. If a county in a region was providing services to an eligibility class of individuals with a developmental disability other than intellectual disability prior to formation of the region, the class of individuals shall remain eligible for the services provided when the region is formed, providing that funds are available to continue such services without limiting or reducing core services. The individual must also meet the requirements in paragraphs 25.15(7) "c," "d," "e" and "f."

- c. The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- d. The individual is at least 18 years of age.
- e. The individual is a resident of this state.



*f.* The individual has a diagnosis of a developmental disability other than an intellectual disability as defined in rule 441—24.1(225C).

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.16(331) Financial eligibility requirements.** The regional service system management plan shall identify basic financial eligibility standards for disability services as defined in Iowa Code section 331.395.

**25.16(1) Income requirements.** Income requirements shall be as defined in Iowa Code section 331.395(1).

**25.16(2) Resource requirements.** An individual must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multiperson household or follow the most recent federal supplemental security income guidelines.

*a.* The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this subrule.

*b.* A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.

*c.* The following resources shall be exempt:

(1) The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

*d.* If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:

(1) A retirement account that is in the accumulation stage.

(2) A medical savings account.

(3) An assistive technology account.

(4) A burial account or trust limited in value as to that allowed in the medical assistance program.

*e.* An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

**25.16(3) Copayment standards.** A regional administrative entity must comply with copayment standards as defined in Iowa Code section 331.395.

*a.* Copayments are allowed for individuals with income above 150 percent of the federal poverty level.

*b.* Copayments in this rule are related to core services as defined in Iowa Code section 331.397.

**25.16(4) Copayment standards required by any federal, state, regional, or municipal program.** Any copayments or other client participation required by any federal, state, regional or municipal program in which the individual participates shall be required by the regional administrative entity. Such copayments include, but are not limited to:

*a.* Client participation for maintenance in a residential care facility through the state supplementary assistance program.

*b.* The financial liability for institutional services paid by counties as provided in Iowa Code section 230.15.

*c.* The financial liability for attorney fees related to commitment as provided by Iowa Code section 229.8.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.17(331) Exempted counties.** If a county has been exempted pursuant to Iowa Code section 331.389 from the requirement to enter into a regional service system, the county and the county's board of supervisors shall fulfill all the requirements of this chapter for a regional service system management plan.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.18(331) Annual service and budget plan.** The annual service and budget plan shall describe the services to be provided and the cost of those services for the ensuing year.

**25.18(1)** The annual service and budget plan is due on April 1 prior to the July 1 implementation of the annual plan and shall be approved by the region's governing board prior to submittal to the department. The initial plan is due on April 1, 2014.

**25.18(2)** The annual service and budget plan shall include but not be limited to:

*a.* The locations of the local access points for services. This shall include the name of the access points including the physical locations and contact information.

*b.* Targeted case management. The targeted case management agencies for the region, including the physical location and contact information for those agencies, shall be included.

*c.* Crisis planning. A list of accredited crisis services available in the region for crisis prevention, response and resolution, including contact information for the agencies responsible, shall be included.

*d.* Intensive mental health services. Identification of the services designated by the region according to rule 441—25.6(331), including the provider name, contact information, and location of each of the following, shall be included:

(1) Access center(s).

(2) ACT services.

(3) Intensive residential services.

(4) Subacute mental health services.

*e.* Scope of services. A description of the scope of services to be provided, a projection of need for the service, and the funding necessary to meet the need shall be included.

(1) The scope shall include the regional core services as defined in rule 441—25.1(331).

(2) The scope shall also include services in addition to the required core services.

*f.* Budget and financing provisions for the next year. The provisions shall address how county, regional, state and other funding sources will be used to meet the service needs within the region.

*g.* Financial forecasting measures. The plan shall describe the financial forecasting measures used in the identification of service need and funding necessary for services.

*h.* The provider reimbursement provisions. The plan shall describe the types of reimbursement methods that will be used, including fee for service, compensating providers for a "system of care" approach, and use of nontraditional providers. A region also shall provide funding approaches that identify and incorporate all services and sources of funding used by the individuals receiving services, including the medical assistance program.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.19(331) Annual service and budget plan approval.** The annual service and budget plan shall be submitted each year by April 1. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the regional annual service and budget plan in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for a fiscal year beginning July 1 shall remain in effect until June 30, subject to amendment.

**25.19(1) Criteria for acceptance.** The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

**25.19(2) Notification.** Except as specified in subrule 25.19(3), the director shall notify the region in writing of the decision on the plan by June 1 of each year. The decision shall specify that either:

*a.* The annual service and budget plan is approved as it was submitted, either with or without supplemental information already requested and received.

*b.* The annual service and budget plan will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

**25.19(3) *Review of late submittals.*** The director may review plans not submitted by April 1 after all plans submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

**25.19(4) *Amendments.*** An amendment to the annual service and budget plan shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the plan, the director must approve the amendment.

*a. Criteria for acceptance.* The director shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the annual service and budget plan and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

*b. Notification.* The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will include why the amendment is not approved.

**25.19(5) *Reconsideration.*** Regions dissatisfied with the director's decision on a plan or an amendment may file a letter with the director requesting reconsideration. The letter requesting reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.20(331) Annual report.** The annual report shall describe the services provided, the cost of those services, the number of individuals served, and the outcomes achieved for the previous fiscal year. The annual report is due on December 1 following a completed fiscal year of implementing the annual service and budget plan. The initial report is due on December 1, 2015. The annual report shall include but not be limited to:

1. Services actually provided.

2. Actual numbers of individuals served.

3. Documentation that each regionally designated access center has met the service standards in subrule 25.6(1).

4. Documentation that each regionally designated ACT team has been evaluated for program fidelity, including a peer review as required by subrule 25.6(2), and documentation of each team's most recent fidelity score.

5. Documentation that each regionally designated subacute service has met the service standards in subrule 25.6(7).

6. Documentation that each regionally designated intensive residential service home or intensive residential service has met the service standards in subrule 25.6(8).

7. Moneys expended.

8. Outcomes achieved.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19]

**441—25.21(331) Policies and procedures manual for the regional service system.** The policies and procedures manual shall describe the policies and process developed to direct the management and

administration of the regional service system. The initial manual is due on April 1, 2014, and will remain in effect subject to amendment.

**25.21(1) Content.** The manual shall include but not be limited to:

*a.* Financing and delivery of services and supports. A description of the region's process used to develop and ensure the ongoing financial accountability and delivery of services outlined in the region's annual service and budget plan shall be included.

*b.* Enrollment. The application and enrollment process that is readily accessible to applicants and their families or authorized representatives shall be included. This procedure shall identify regional access points and where applicants can apply for services and how and when the applications will reach the regional administrative entity's designated staff for processing.

*c.* Eligibility. The process utilized to determine eligibility shall be included in the manual and shall include but not be limited to:

(1) The criteria used to authorize or deny funding for services and supports. This shall include guidelines for who is eligible to receive services and supports by eligibility group, and type of service or support.

(2) Financial eligibility and copayment criteria, which shall meet the requirements of rule 441—25.16(331).

(3) The time frames for conducting eligibility determination that provide for timely access to services, including necessary and immediate services not to exceed ten days.

(4) The process for development of a written notice of decision. The time frame for sending a written notice of decision to the individual and guardian (if applicable) and the service providers identified in the notice shall be included. The notice of decision shall:

1. Explain the action taken on the application and the reasons for that action.
2. State what services are approved and name the service providers.
3. Outline the applicant's right to appeal.
4. Describe the appeal process.

*d.* Utilization of and access to services. The process for managing utilization of and access to services and other assistance shall be included. The process shall describe how coordination between the services included in the annual service and budget plan and the disability services administered by the state and others will be managed.

*e.* Quality management and improvement process. The quality management and improvement process shall at a minimum meet the requirements of the department's outcome and performance measures process as outlined in Iowa Code sections 225C.4(1)"j" and 225C.6A.

*f.* Risk management and fiscal viability. If the region contracts with a private entity, the manual must include risk management provisions and fiscal viability of the annual services and budget plan.

*g.* Targeted case management.

(1) Designation of targeted case management providers. The process used to identify and designate targeted case management providers for the region shall be described. This process shall include the requirement for the implementation of evidence-based practice models of case management within the region. Requirements of this practice include:

1. Providing the individual receiving the case management with a choice of providers.
2. Allowing a service provider to be the case manager but prohibiting the provider from referring that individual only to services administered by the provider.
3. Provisions to ensure compliance with, but not exceed, federal requirements for conflict-free case management.

(2) Qualifications of targeted case managers. A region's manual shall require that any targeted case managers or other persons providing service coordination while working for the designated provider meet the qualifications of qualified case managers and supervisors as defined in rule 441—24.1(225C).

(3) Targeted case management and service coordination services. Targeted case management and service coordination services utilized in a regional service system shall include but are not limited to the following as defined in Iowa Code section 331.393(4)"g":

1. Performance and outcome measures relating to the health, safety, work performance, and community residency of the individuals receiving the services.

2. Standards for delivery of the services, including but not limited to the social history, assessment, service planning, incident reporting, crisis planning, coordination, and monitoring for individuals receiving the services.

3. Methodologies for complying with the requirements of paragraph 25.21(1)“g.” Methodologies may include the use of electronic record keeping and remote or Internet-based training.

*h.* System of care approach plan.

*i.* Decentralized service provision. Measures to provide services in a dispersed manner that meet the minimum access standards of core services and that utilize the strengths and assets of the service providers within and available to the region shall be included.

*j.* Provider network formation and management. The manual shall require that providers that are subject to license, accreditation or approval meet established standards. The manual shall detail the approval process, including criteria, developed to select providers that are not currently subject to license, accreditation or approval standards. The manual shall identify the process the regional administrative entity will use to contract with providers and manage the provider network to ensure it meets the needs of the individuals in the region. The provider network will include but is not limited to the following:

(1) A contract with a community mental health center that provides services in the individual’s region or with a federally qualified health center that provides psychiatric and outpatient mental health services in the individual’s region.

(2) Contracts with licensed and accredited providers to provide each service in the required core service domains.

(3) Adequate numbers of licensed and accredited providers to ensure availability of core services so that there is no waiting list for services due to lack of available providers.

(4) A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity.

*k.* Service provider payment provisions. A policy for payment of service providers which describes the method and process of paying for services and supports delivered to the region shall be included.

*l.* Grievance processes. The manual shall develop and implement processes for appealing the decisions of the regional administrative entity in the following circumstances:

(1) Nonexpedited appeal process. The appeal process shall be based on objective criteria, specify time frames, provide for notification in accessible formats of the decisions to all parties, and provide some assistance to individuals with disabilities using the process. Responsibility for the final step in the appeal process shall be a state administrative law judge in nonexpedited appeals.

(2) Expedited appeal process. This appeal process is to be used when the decision of the regional administrative entity concerning an individual varies from the type and amount of service identified to be necessary for the individual in a clinical determination made by a mental health professional and the mental health professional believes that the failure to provide the type and amount of service identified could cause an immediate danger to an individual’s health or safety. This appeal process shall be performed by a mental health professional who is either the administrator of the division of mental health and disability services of the department of human services or the administrator’s designee.

1. The appeal shall be filed within five days of receipt of the notice of decision by the regional administrative entity.

2. The expedited review by the division administrator or designee shall take place within two days of receipt of the request, unless more information is needed. There is an extension of two days from the time the new information is received.

3. The administrator shall issue an order, including a brief statement of findings of fact, conclusions of law, and policy reasons for the order, to justify the decision made concerning the expedited review. If the decision concurs with the contention that there is an immediate danger to the individual’s health or safety, the order shall identify the type and amount of service which shall be

provided for the individual. The administrator or designee shall give such notice as is practicable to individuals who are required to comply with the order. The order is effective when issued.

4. The decision of the administrator or designee shall be considered a final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

*m.* Implementation of interagency and multisystem collaboration and care coordination. The policies and procedures manual shall describe how the region will collaborate with other funders, other regional service systems, service providers, case management, individuals and their families or authorized representatives, and advocates to ensure that authorized services and supports are responsive to individuals' needs, consistent with system principles, and cost-efficient. The manual shall describe the process for collaboration with the court to ensure alternatives to commitment and to coordinate funding for services to individuals who are under court-ordered commitment services pursuant to Iowa Code chapter 229.

*n.* Addressing multioccurring needs. The policies and procedures manual shall include criteria and measures to be used to address the needs of individuals who have two or more co-occurring mental health, intellectual or other developmental disability, brain injury, or substance-related disorders. The manual shall also include criteria and measures to be used to address the needs of individuals with specialized needs.

*o.* Service management and functional assessment. The policies and procedures manual shall describe how functional assessments and service management will be incorporated in accordance with applicable requirements.

*p.* Service system management. The policies and procedures manual shall identify whether the region will be directly implementing a system of service management or will contract with a private entity to manage the regional service system. If the region contracts with a private entity, the region will ensure that all requirements of Iowa Code section 331.393 and these administrative rules are fulfilled.

*q.* Assistance to other than core service populations. The policies and procedures manual shall specify the services populations, other than core service populations, to whom the region will provide assistance if funding is available.

*r.* Waiting list criteria. The policies and procedures manual shall specify whether the region will use waiting lists. If the policy and procedures manual specifies the use of waiting lists for funding services and supports, it shall specify criteria for the use and review of each waiting list, including the criteria to be used to determine how and when an individual will be placed on a waiting list. The criteria will include how core services and additional core services will be impacted the least by budgetary limitations. The manual shall specify how waiting list data will be used in future planning.

**25.21(2) Approval.** The manual shall be submitted by April 1, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014. The manual shall be approved by the region's governing board and is subject to approval by the director of human services. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the manual in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for the fiscal year beginning July 1, 2014, shall remain in effect subject to amendment.

*a. Criteria for acceptance.* The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

*b. Notification.*

(1) Except as specified in subparagraph 25.21(2)"b"(2), the director shall notify the region in writing of the decision on the plan by June 1, 2014. The decision shall specify that either:

1. The policies and procedures manual is approved as it was submitted, either with or without supplemental information already requested and received.

2. The policies and procedures manual will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

(2) Review of late submittals. The director may review manuals not submitted by April 1, 2014, after all manuals submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

**25.21(3) Amendments.** An amendment to the policy and procedures manual shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the manual, the director must approve the amendment.

*a. Criteria for acceptance.* The director, in consultation with the state commission, shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the policy and procedures manual and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

*b. Notification.* The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will explain why the amendment is not approved.

**25.21(4) Reconsideration.** Regions dissatisfied with the director's decision on a manual or an amendment may file a letter with the director requesting reconsideration. The letter of reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

These rules are intended to implement Iowa Code sections 331.388 to 331.398.  
[ARC 1173C, IAB 11/13/13, effective 1/1/14]

**441—25.22 to 25.40** Reserved.

DIVISION III  
MINIMUM DATA SET

**441—25.41(331) Minimum data set.** Each county shall maintain data on all clients served through the MH/DD services fund.

**25.41(1) Submission of data.** Each county shall submit to DHS a copy of the data regarding each individual that the county serves through the central point of coordination process.

*a.* DHS state payment program, state supplementary assistance program, mental health institutes, state resource centers, Medicaid program, and Medicaid managed care contractors shall provide the equivalent data in a compatible format on the same schedule as the required submission from the counties.

*b.* DHS shall maintain the data in the data analysis unit for research and analysis purposes only. Only summary data shall be reported to policymakers or the public.

**25.41(2) Data required.** The data to be submitted are as follows:

*a.* Basic client information including a unique identifier, name, address, county of residence and county of legal settlement.

*b.* The state I.D. number for state payment cases.

*c.* Demographic information including date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of insurance, insurance carrier, veterans' status, guardianship status, legal status in the system, source of referral, diagnosis in the current version of the DSM, diagnosis in the current version of the ICD, disability group (i.e., intellectual disability, developmental disability, chronic mental illness, mental illness), central point of coordination (county number preceded by A 1), and central point of coordination (CPC) name.

*d.* Service information including the decision on services, date of decision, date client terminated from CPC services and reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating each service, approved units of services, unit rate for service, expenditure data, and provider data.

*e.* Counties shall not be penalized in any fashion for failing to collect data elements in situations of crisis or in outreach efforts to identify or engage people in needed mental health services. For the purposes of this rule:

(1) Situations of crisis include but are not limited to voluntary and involuntary hospitalizations, legal and transportation services associated with involuntary hospitalizations, emergency outpatient services, mobile crisis team services, jail diversion services, mental health services provided in a county jail, and other services for which the county is required to pay but does not have access to the client to collect the required information.

(2) Outreach efforts to identify or engage people in needed mental health services include but are not limited to mental health advocate services; services for homeless persons, refugees, or other legal immigrants; services for state cases who do not have documentation with them and are unable to help the county locate appropriate records; consultation; education to raise public awareness; 12-step or other support groups for persons with dual disorders; and drop-in centers.

*f.* Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 100 percent reporting of the data elements listed in this paragraph. Beginning with the data reported for state fiscal year 2008, less than 100 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph “*e*”:

- (1) Client identifiers:
  1. Lname3 (the first three letters of the client’s last name).
  2. Last4SSN (the last four digits of the client’s social security number).
  3. SEX (the client’s sex).
  4. BDATE (the client’s birth date).
- (2) CPC (central point of coordination).
- (3) Payment information:
  1. PYMTDATE (CoMIS payment date).
  2. FUND CODE (CoMIS fund code).
  3. DG (CoMIS diagnosis).
  4. COACODE (CoMIS chart of accounts code).
  5. BEGDATE (CoMIS service beginning date).
  6. ENDDATE (CoMIS service ending date).
  7. UNITS (CoMIS units of service).
  8. COPD (CoMIS county paid).
- (4) ValidSSN (valid social security number indicator).
- (5) IsPerson (IsPerson indicator).

*g.* Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 90 percent reporting of the data elements listed in this paragraph beginning with the data reported for fiscal year 2008. Less than 90 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph “*e*”:

- (1) Application Date (application date).
- (2) RESCO (residence county).
- (3) LEGCO (legal county).
- (4) Provider ID (vendor number).

*h.* The department shall analyze the data received on or before December 1 each year by December 15 or by the next business day if December 15 falls on a weekend or holiday.

(1) When a county’s data submission does not meet the specifications in paragraph “*f*” or “*g*,” the department will notify the county by email.



(2) The county shall have 30 days from the date of the email notice to submit the missing data or to provide an explanation of why the data cannot be reported.

(3) If the county does not report the data or provide an adequate explanation within 30 days, the department shall find the county in noncompliance.

i. The department shall post the aggregate reports received by December 1 on the department’s Web site within 90 days.

**25.41(3) Method of data collection.** A county may choose to collect this information using the county management information system (CoMIS) that was designed by the department or may collect the information through some other means. If a county chooses to use another system, the county must be capable of supplying the information in the same format as CoMIS.

a. Except as provided in subparagraph (3), each county shall submit the following files in Microsoft Excel format (version 97 to 2000) or comma-delimited text file (CSV) format using data from the associated CoMIS table or from the county’s chosen management information system:

<u>Files to submit</u>	<u>Associated CoMIS Table</u>
WarehouseClient.xls or WarehouseClient.csv	Client Data
WarehouseIncome.xls or WarehouseIncome.csv	Income Review
WarehousePayment.xls or WarehousePayment.csv	Payment
WarehouseProvider.xls or WarehouseProvider.csv	Provider
WarehouseProviderServices.xls or WarehouseProviderServices.csv	tblProviderServices
WarehouseService.xls or WarehouseService.csv	Service Authorizations

(1) Paragraphs “b” through “g” list the data required in each file and specify the structure or description for each data item to be reported.

(2) The field names used in the report files must be exactly the same as indicated in the corresponding paragraph, including spaces, and must be entered in the first row for each sheet.

(3) The file labeled WarehouseService.xls or WarehouseService.csv or service authorization (described in paragraph “g” of this subrule) shall be removed from this requirement on June 30, 2011, if data from this file have not been used by that date.

b. File name: WarehouseClient.xls or WarehouseClient.csv.

Sheet name: Warehouse\_Client\_Transfer\_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute

Field Name	Data Type	Field Size	Format	Description
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
Last Update	Date	10	mm/dd/yyyy	Date of last update to client record
SID	Text	8	9999999a	State identification number of client, if applicable (format of a valid number is 7 digits plus 1 alphabetical character).
ADD1	Text	50		First address line
ADD2	Text	50		Second address line (if applicable)
CITY	Text	50		City address line
STATE	Text	2		State code
ZIP	Number	5	0 decimal places	5-digit ZIP code
ETHN	Number	1	0 decimal places	Ethnicity of client: 0 = Unknown 1 = White, not Hispanic 2 = African-American, not Hispanic 3 = American Indian or Alaskan native 4 = Asian or Pacific Islander 5 = Hispanic 6 = Other (biracial; Sudanese; etc.)
MARITAL	Number	1	0 decimal places	Marital status of client: 1 = Single, never married 2 = Married (includes common-law marriage) 3 = Divorced 4 = Separated 5 = Widowed
EDUC	Number	2	0 decimal places	Education level of the client
RARG	Number	2	0 decimal places	Residential arrangement of client: 1 = Private residence/household 2 = State MHI 3 = State resource center 4 = Community supervised living 5 = Foster care or family life home 6 = Residential care facility 7 = RCF/MR 8 = RCF/PMI 9 = Intermediate care facility 10 = ICF/MR 11 = ICF/PMI 12 = Correctional facility 13 = Homeless shelter or street 14 = Other
LARG	Number	1	0 decimal places	Living arrangement of client: 1 = Lives alone 2 = Lives with relatives 3 = Lives with persons unrelated to client
INS	Number	1	0 decimal places	Health insurance owned by client: 1 = Client pays 3 = Medicaid 4 = Medicare 5 = Private third party 6 = Not insured 7 = Medically Needy

Field Name	Data Type	Field Size	Format	Description
INSCAR	Text	50		First insurance company name, if applicable
INSCAR1	Text	50		Second insurance company name, if applicable
INSCAR2	Text	50		Third insurance company name, if applicable
VET	Text	1		Veteran status of client: Y = Yes N = No
CONSERVATOR	Number	1	0 decimal places	Conservator status of client: 1 = Self 2 = Other
GUARDIAN	Number	1	0 decimal places	Guardian status of client: 1 = Self 2 = Other
LEGSTAT	Number	1	0 decimal places	Legal status of client: 1 = Voluntary 2 = Involuntary, civil commitment 3 = Involuntary, criminal commitment
REFSO	Number	1	0 decimal places	Referral source of client: 1 = Self 2 = Family or friend 3 = Targeted case management 4 = Other case management 5 = Community corrections 6 = Social service agency other than case management 7 = Other
DSM (current version)	Text	50		DSM (current version) diagnosis code of client
ICD (current version)	Text	50		ICD (current version) diagnosis code (optional for county use; not tied to CoMIS entry)
DG	Number	2	0 decimal places	Disability group of client: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
Application Date	Date	10	mm/dd/yyyy	Date of client's initial application
Outcome decision	Number	1	0 decimal places	Decision on client's application: 1 = Application accepted 2 = Application denied 3 = Decision pending
Decision date	Date	10	mm/dd/yyyy	Date decision was made on client's application
Denial reason	Text	2		Denial reason code: 00 = Not applicable 01 = Over income guidelines 1A = Over resource guidelines 02 = Does not meet county plan criteria 2A = Legal settlement in another county 2B = State case 3A = Brain injury 3B = Alzheimer's 3C = Substance abuse 3D = Other 04 = Does not meet service plan criteria 05 = Client desires to discontinue process 5A = Client fails to return requested information

Field Name	Data Type	Field Size	Format	Description
Client exit date from CPC	Date	10	mm/dd/yyyy	Date client was terminated from CPC services
Exit reason	Number	1	0 decimal places	Reason client left the CPC system: 0 = Unknown 1 = Client voluntarily withdrew 2 = Client deceased 3 = Unable to locate consumer 4 = Ineligible due to reasons other than income 5 = Ineligible, over income guidelines 6 = Client moved out of state 7 = Client no longer needs service 8 = Client has legal settlement in another county
Review Date	Date	10	mm/dd/yyyy	Date of last application review
PhoneNumber	Text	50		Phone number of client
ValidSSN	Text	3	Generated for CoMIS users in the data extract only	Populate this field with YES if the client has a valid social security number. If the client does not have a valid social security number, populate this field with NO.
IsPerson	Text	3	Generated for CoMIS users in the data extract only	Populate this field with YES if the client is a person. If the client entry represents a nonperson such as administrative costs, populate this field with NO.

c. File name: WarehouseIncome.xls or WarehouseIncome.csv.

Sheet name: Warehouse\_Income\_Transfer\_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
EMPL	Number	2	0 decimal places	Employment situation of client: 1 = Unemployed, available for work 2 = Unemployed, unavailable for work 3 = Employed full-time 4 = Employed part-time 5 = Retired 6 = Student 7 = Work activity employment 8 = Sheltered work employment 9 = Supported employment 10 = Vocational rehabilitation 11 = Seasonally employed 12 = In the armed forces 13 = Homemaker 14 = Other or not applicable 15 = Volunteer
House Hold Size	Number	2	0 decimal places	Number of people in client's household
INCSOUR	Number	2	0 decimal places	Primary income source of client: 1 = Family and friends 2 = Private relief agency 3 = Social security disability benefits 4 = Supplemental Security Income 5 = Social security benefits 6 = Pension 7 = Food assistance 8 = Veterans benefits 9 = Workers compensation 10 = General assistance 11 = Family investment program (FIP) 12 = Wages
Public Assistance Payments	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security Disability	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
SSI	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
VA Benefits	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
R/R Pension	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Child Support	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Employment Wages	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Dividend Interest	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Other Income	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Description 1	Text	50		Description of "Other Income"
Cash on hand	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Checking	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Savings	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Stocks/Bonds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Time Certificates	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)

Field Name	Data Type	Field Size	Format	Description
Trust Funds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Other Resources	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 2	Text	50		Description of "Other Resources" (where applicable)
Other Resources 2	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 3	Text	50		Description of "Other Resources 2"
Date reviewed	Date	10	mm/dd/yyyy	Date income was last reviewed (where applicable)

d. File name: WarehousePayment.xls or WarehousePayment.csv. Sheet name: Warehouse\_Payment\_Transfer\_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
PYMTDATE	Date	10	mm/dd/yyyy	Date county approves or makes payment
VENNAME	Text	50		Vendor or provider paid
COCODE	Number	3	0 decimal places	County where service was provided
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for payment
BEGDATE	Date	10	mm/dd/yyyy	Beginning date of payment period
ENDDATE	Date	10	mm/dd/yyyy	Ending date of payment period
UNITS	Number	4	0 decimal places	Number of service units for payment
COPD	Currency	14	2 decimal places	Amount paid by the county
RECEIVED	Currency	14	2 decimal places	Amount received for reimbursement (if applicable)

e. File name: WarehouseProvider.xls or WarehouseProvider.csv. Sheet name: Warehouse\_Provider\_Transfer\_Que. (If the provider has more than one office location, enter information for the headquarters office.)

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
Provider Address1	Text	50		Provider address line 1
Provider Address2	Text	50		Provider address line 2 (if applicable)
City	Text	50		Provider city
State	Text	2		Provider state code
Zip	Text	10		Provider ZIP code
COCODE	Number	3	0 decimal places	Provider county code
PhoneNumber	Text	50		Provider phone number
Date of Last Update	Date	10	mm/dd/yyyy	Provider last updated date

f. File name: WarehouseProviderServices.xls or WarehouseProviderServices.csv. Sheet name: Warehouse\_Provider\_Services\_Tra.

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for service
RATE	Currency	14	2 decimal places	Payment rate

g. File name: WarehouseService.xls or WarehouseService.csv. Sheet name: Warehouse\_Service\_Transfer\_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 200 = Iowa nonresident 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
FUND CODE	Text	10		Fund code for service
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other category
COACODE	Number	5	0 decimal places	Chart of accounts code for service
Begin Date	Date	10	mm/dd/yyyy	Beginning date of service period
End Date	Date	10	mm/dd/yyyy	Ending date of service period
Ending Reason	Number	1	0 decimal places	Reason for terminating approval of service: 0 = NA 1 = Voluntary withdrawal 2 = Client no longer needs service 3 = Ineligible, over income guidelines 4 = Ineligible due to other than income 5 = Client moved out of state 6 = Client deceased 7 = Reauthorization
Units	Number	4	0 decimal places	Average number of service units approved monthly
Rate	Currency	14	2 decimal places	Dollar amount per service unit
Review Date	Date	10	mm/dd/yyyy	Date for next service review

This rule is intended to implement Iowa Code sections 331.438 and 331.439.  
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

**441—25.42 to 25.50** Reserved.

DIVISION IV  
INCENTIVE AND EFFICIENCY POOL FUNDING

PREAMBLE

These rules establish requirements for counties to receive funding from the incentive and efficiency pool. To be eligible for these funds, a county must select five performance indicators, submit a proposal, collect data, report data, and show improvement over time on the selected performance indicators.

**441—25.51(77GA, HF2545) Desired results areas.** In order to receive funds from the incentive and efficiency pool established in 1998 Iowa Acts, House File 2545, section 8, subsection 2, each county shall collect and report performance measure data in the following areas:

**25.51(1) Equity of access.** Each county shall measure the extent to which services are available and used. Each county shall:

*a.* Report annually the total number of consumers served, as well as an unduplicated total of the number of consumers served by disability category.

*b.* Calculate and report annually the percentage of service provision by dividing the number of consumers served in a year by the county's population as defined in 1998 Iowa Acts, House File 2545, section 7.

*c.* Calculate and report annually the percentage of denial of access by dividing the number of new, completed applications denied by the total number of new applications for service that year. A new, completed application shall be defined as an initial application of a consumer or any former consumer who is reapplying for service eligibility after more than 30 days of not being enrolled in the system, for which the consumer has supplied the information required on the application form.

*d.* Report annually the county's eligibility guidelines, which may include, but are not limited to, the income level below which an individual or family must be in order to be eligible for county-funded



services, the maximum amount of resources which an individual or family may have in order to be eligible for county-funded services, covered populations, and service access criteria.

**25.51(2) Community-based supports.** Each county shall measure the extent to which community-based supports are available and used. Each county shall calculate and report annually:

*a.* The service setting percentage by dividing the unduplicated number of persons served in each of the following service settings in a fiscal year by the total unduplicated number of consumers served, both in total and by population group: mental health institutes, state hospital schools, intermediate care facilities for the mentally retarded, other living arrangements over five beds as captured by the county chart of accounts, and employment settings which include sheltered workshops, enclaves and supported employment.

*b.* The home-based percentage by subtracting the number of consumers currently being served in residential placements from the total unduplicated number of consumers served, and dividing the difference by the total number of consumers served. The calculation shall be made both in total and by population group.

*c.* The inpatient spending percentage by dividing the amount the county spent for inpatient services by the amount the county spent for outpatient services. Each county shall also divide the unduplicated number of consumers who received inpatient services during the fiscal year by the total unduplicated number of consumers who received services during that same fiscal year. Inpatient services shall be defined as any acute care for which the county is wholly or partially financially responsible.

**25.51(3) Consumer participation.** Each county shall measure the extent to which consumers participate in all aspects of the service system.

*a.* Each county shall report annually on the number of opportunities during the year for consumers to participate in planning activities, which may include, but are not limited to, open forums, focus groups, consumer advisory committee meetings, and planning council meetings by calculating the total number of consumers participating in these activities and dividing by the unduplicated number of consumers served and also by the total population of the county. In addition, the county shall report duplicated and unduplicated total attendance at all of these meetings. These calculations shall be made for consumers and family members separately.

*b.* Each county which has a planning group shall calculate and report annually the planning group percentage by dividing the number of consumers who actively serve on the planning group by the total number of people on the planning group. This calculation shall be made for consumers and family members separately. For the purposes of this subrule, a planning group is any group of individuals designated by the board of supervisors, or if no designation has been made, any group acknowledged by the central point of coordination administrator as assisting in the development of the county management plan.

*c.* Each county shall conduct a consumer satisfaction survey following adoption of more detailed rules for the survey.

**25.51(4) Administration.** Each county shall measure the extent to which the county services system is administered efficiently and effectively. Each county shall:

*a.* Calculate and report annually the administrative cost percentage by dividing the amount spent administering the county services system by the total amount spent from the services fund for the fiscal year.

*b.* Calculate and report annually the service responsiveness average by measuring the number of days between the date a new, completed application was submitted and the date a notice of decision of eligibility was sent to the consumer, adding all of these numbers of days, and dividing by the total number of new, completed applications for the fiscal year. A new, completed application shall be defined as an initial application of a consumer or an application of any former consumer who is reapplying for service eligibility after more than 30 days of not being enrolled in the system, for which the consumer has supplied the information required on the application form.

*c.* Report annually the number of appeals filed as a percent of the unduplicated total number of consumers served per year.

**441—25.52(77GA, HF2545) Methodology for applying for incentive funding.** Beginning with the county management plan for the fiscal year which begins July 1, 1999, each county applying for funding under 1998 Iowa Acts, House File 2545, section 8, subsection 2, shall include with its county management plan a performance improvement proposal for improving the county's performance on at least five performance measures. Three of the measures must be selected from at least two of the desired results areas stated in rule 441—25.51(77GA, HF2545). For the remaining two measures, the county either may propose measures not identified in these rules or may use measures described in these rules. A performance improvement proposal is not a mandatory element of a county management plan.

**25.52(1) *Performance improvement proposal.*** Each county shall identify the performance measures which the county has targeted for improvement and shall propose a percentage change for each indicator. The proposal shall include the county's rationale for selecting the indicators and may include any supporting information the county deems necessary. The proposal shall describe the process the county will use to involve consumers in the evaluation.

**25.52(2) *Committee responsibility.*** The state county management committee shall review all county proposals, and may either accept the proposal, request modifications, or reject the proposal. In order to interpret and provide context for each county's performance improvement proposal, the state county management committee shall, by January 1, 1999, establish the background data to be collected and aggregated for all counties.

**25.52(3) *County ineligibility.*** A county which does not have an accepted proposal prior to July 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to July 1. The petition shall describe the circumstances which will cause the proposal to be delayed and identify the date by which the proposal will be submitted. In addition, the state county management committee may grant an extension for the purposes of negotiation.

**441—25.53(77GA, HF2545) Methodology for awarding incentive funding.** Each county shall report on all performance measures listed in this division, plus any additional performance measures the county has selected, by December 1 of each year.

**25.53(1) *Reporting.*** Each county shall report performance measure information on forms, or by electronic means, developed for the purpose by the department in consultation with the state county management committee.

**25.53(2) *Scoring.*** The department shall analyze each county's report to determine the extent to which the county achieved the levels contained in the proposal accepted by the state county management committee. Prior to distribution of incentive funding to counties, results of the analysis shall be shared with the state county management committee.

**25.53(3) *County ineligibility.*** A county which does not report performance measure data by December 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to December 1. The petition shall describe the circumstances which will cause the report to be delayed and identify the date by which the report will be submitted.

**441—25.54(77GA, HF2545) Subsequent year performance factors.** For any fiscal year which begins after July 1, 1999, the state county management committee shall not apply any additional performance measures until the county management information system (CoMIS) developed and maintained by the division of mental health and developmental disabilities has been modified, if necessary, to collect and calculate required data elements and performance measures and each county has been given the opportunity to establish baseline measures for those measures.

**441—25.55(77GA, HF2545) Phase-in provisions.**

**25.55(1) *State fiscal year 1999.*** For the fiscal year which begins July 1, 1998, each county shall collect data as required above in order to establish a baseline level on all performance measures. A county

which collects and reports all required data by December 1, 1999, shall be deemed to have received a 100 percent score on the county's performance indicators.

**25.55(2) State fiscal year 2000.** A county which submits a proposal with its management plan for the fiscal year which begins July 1, 1999, and reports the levels achieved on the selected performance measures by December 1, 2000, shall be deemed to have received a 100 percent score on the county's performance indicators, regardless of the actual levels achieved.

These rules are intended to implement 1998 Iowa Acts, House File 2545, section 8, subsection 2.

**441—25.56 to 25.60** Reserved.

DIVISION V  
RISK POOL FUNDING

PREAMBLE

These rules establish a risk pool board to administer the risk pool fund established by the legislature and set forth the requirements for counties for receiving and repaying funding from the fund.

**441—25.61(426B) Definitions.**

*"Available pool"* means those funds remaining in the risk pool less any actuarial and other direct administrative costs.

*"Central point of coordination (CPC)"* means the administrative entity designated by a county board of supervisors, or the boards of a consortium of counties, to act as the single entry point to the service system as required in Iowa Code section 331.440.

*"Commission"* means the mental health, mental retardation, developmental disabilities, and brain injury commission.

*"Division"* means the mental health and disability services division of the department of human services.

*"Mandated services"* means those services for which a county is required to pay. Mandated services include, but may not be limited to, the following:

1. The costs for commitments for persons with mental illness, chronic mental illness, mental retardation, or developmental disabilities.
2. Inpatient services at the state mental health institutes for persons with mental illness or chronic mental illness.
3. Inpatient services at the state resource centers for persons with mental retardation or developmental disabilities.
4. Medicaid-funded care in an intermediate care facility for persons with mental retardation.
5. Medicaid-funded partial hospitalization and day treatment services for persons with chronic mental illness.
6. Medicaid-funded case management services for persons with mental retardation or developmental disabilities and for anyone not covered under the Iowa Plan.
7. Services provided under the Medicaid home- and community-based services mental retardation waiver.
8. Services provided under the Medicaid home- and community-based services brain injury waiver for which the county is responsible according to rule 441—83.90(249A).
9. Medicaid habilitation services for persons with chronic mental illness.

*"Services fund"* means a county's mental health, mental retardation, and developmental disabilities services fund created in Iowa Code section 331.424A.

**441—25.62(426B) Risk pool board.** This ten-member board consists of two county supervisors, two county auditors, a member of the commission who is not a member of a county board of supervisors, a member of the county finance committee created in Iowa Code chapter 333A who is not an elected official, a representative of a provider of mental health or developmental disabilities services selected

from nominees submitted by the Iowa Association of Community Providers, and two central point of coordination administrators, all appointed by the governor, subject to confirmation by two-thirds of the members of the senate, and one member appointed by the director of the department of human services.

**25.62(1) Organization.**

a. The members of the board shall annually elect from the board's voting membership a chairperson and vice-chairperson of the board.

b. Members appointed by the governor shall serve three-year terms.

**25.62(2) Duties and powers of the board.** The board's powers and duties are to make policy and to provide direction for the administration of the risk pool established by Iowa Code section 426B.5, subsection 2. In carrying out these duties, the board shall do all of the following:

a. Recommend to the commission for adoption rules governing the risk pool fund.

b. Determine application requirements to ensure prudent use of risk pool assistance.

c. Accept or reject applications for assistance in whole or in part.

d. Review the fiscal year-end financial records for all counties that are granted risk pool assistance and determine if repayment is required.

e. Approve actuarial and other direct administrative costs to be paid from the pool.

f. Compile a list of requests for risk pool assistance that are beyond the amount available in the risk pool fund for a fiscal year and the supporting information for those requests and submit the list and supporting information to the commission, the department of human services, and the general assembly.

g. Perform any other duties as mandated by law.

**25.62(3) Board action.**

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, an action is carried by a majority of the qualified members of the board.

**25.62(4) Board minutes.**

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division.

**25.62(5) Board meetings.**

a. The board shall meet in August of each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any county making application for risk pool funds must be represented at the board meeting for awarding funds when that request is considered.

(1) The division shall notify the county of the date, time and location of the meeting.

(2) Any other persons with questions about the date, time or location of the meeting may contact the Administrator, Division of Mental Health and Disability Services, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, telephone (515)281-7277.

c. The board shall comply with applicable provisions of Iowa's open meetings law, Iowa Code chapter 21.

**25.62(6) Records.** Any records maintained by the board or on behalf of the board shall be made available to the public for examination in compliance with Iowa's open records law, Iowa Code chapter 22. To the extent possible, before submitting applications, records and documents, applicants shall delete any confidential information. These records shall be maintained in the office of the division.

**25.62(7) Conflict of interest.** A board member cannot be a part of any presentation to the board of that board member's county's application for risk pool funds nor can the board member be a part of any action pertaining to that application.

**25.62(8) Robert's Rules of Order.** In cases not covered by these rules, Robert's Rules of Order shall govern.

**25.62(9) Report.** On or before March 1 and September 1 of each fiscal year, the department of human services shall provide the risk pool board with a report of the financial condition of each funding source administered by the board. The report shall include, but is not limited to, an itemization of the

funding source's balances, types and amount of revenues credited and payees and payment amounts for the expenditures made from the funding source during the reporting period.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

**441—25.63(426B) Application process.**

**25.63(1) Applicants.** A county may be eligible for risk pool assistance when the county demonstrates that it meets the conditions in this subrule.

*a. Basic eligibility.*

(1) The county complies with the requirements of Iowa Code section 331.439.

(2) The county levied the maximum amount allowed for the county's services fund under Iowa Code section 331.424A for the fiscal year of application.

(3) In the fiscal year that commenced two years before the fiscal year of distribution, the county's services fund ending balance under generally accepted accounting principles was equal to or less than 20 percent of the county's actual gross expenditures for that fiscal year.

*b. Circumstances indicating need for assistance.* Risk pool assistance is needed for one or more of the following purposes:

(1) To continue support for mandated services.

(2) To avoid the need for reduction or elimination of:

1. Critical services, creating risk to a consumer's health or safety;

2. Critical emergency or mobile crisis services, creating risk to the public's health or safety;

3. Services or other support provided to an entire disability category; or

4. Services or other support provided to maintain consumers in a community setting, creating risk of placement in a more restrictive, higher-cost setting.

**25.63(2) Application procedures.**

*a. Format for submission.* The county shall submit the application package electronically or send an original plus 15 copies to the division. Facsimiles are not acceptable.

*b. Deadline.* The division must receive the application no later than 4:30 p.m. on July 1 of each year; or, if July 1 is a holiday, Saturday or Sunday, the division must receive the application no later than 4:30 p.m. on the first working day thereafter.

*c. Signature.* The application shall be signed and dated by both the chairperson of the county board of supervisors and the central point of coordination administrator.

*d. Notice of receipt.* Staff of the division shall notify each county of receipt of the county's application.

*e. Content.* In addition to Form 470-3723, Risk Pool Application, the application package shall include the following forms for the fiscal year that commenced two years before the fiscal year of distribution:

(1) Form 634C, Service Area 4 Supporting Detail (pages 1 to 8).

(2) Form 638R, Statement of Revenues, Expenditures, and Changes in Fund Balance—Actual and Budget (pages 1 and 2).

(3) If the budget has been amended, Form 653A-R, Record of Hearing and Determination on the Amendment to County Budget (sheet 2), as last amended.

**25.63(3) Request for additional information.** Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county within four working days after July 1 to request the information needed to complete the application. If July 1 is a holiday, Saturday or Sunday, the division shall make this contact within five working days after July 1. The county shall submit the required information within five working days from the date of the division's request for the additional information.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

**441—25.64(426B) Methodology for awarding risk pool funding.** The risk pool board shall make an eligibility decision on each application within 45 days after receiving the application and shall make a funding decision no later than August 15.

**25.64(1) Notice of decision.** The risk pool board shall send a notice of decision of the board's action to the chairperson of the applying county's board of supervisors. Copies of the notice of decision shall be sent to the county auditor and the central point of coordination administrator.

**25.64(2) Distribution of funds.** The total amount of the risk pool shall be limited to the available pool for a fiscal year.

*a.* If the total dollar amount of the approved applications exceeds the available pool, the board shall prorate the amount paid for an approved application. The funds will be prorated to each county based upon the proportion of each approved county's request to the total amount of all approved requests.

*b.* The division shall authorize the issuance of warrants payable to the county treasurers for the amounts due. The warrants shall be issued on or before September 15.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

**441—25.65(426B) Repayment provisions.**

**25.65(1) Required repayment.** Counties shall be required to repay risk pool funds if the county's actual need for risk pool assistance was less than the amount of risk pool assistance granted to the county. The county shall refund the lesser of:

*a.* The amount of assistance awarded; or

*b.* An amount such that the fund balance after refund will not exceed 5 percent of the expenditures for the year as determined on a modified accrual basis.

**25.65(2) Year-end report.** Each county granted risk pool funds shall complete a year-end financial report as required by Iowa Code section 225C.6A(2)(c)(3). The division shall review the accrual information and notify the mental health risk pool board if any county that was granted assistance in the prior year received more than the county's actual need based on the submitted financial report.

**25.65(3) Notification to county.** The chairperson of the mental health risk pool board shall notify each county by January 1 of each fiscal year of the amount to be reimbursed. The county shall reimburse the risk pool within 30 days of receipt of notification by the chairperson of the mental health risk pool board. If a county fails to reimburse the mental health risk pool, the board may request a revenue offset through the department of revenue. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the central point of coordination administrator of the county.

[ARC 7879B, IAB 6/17/09, effective 6/1/09]

**441—25.66(426B) Appeals.** The risk pool board may accept or reject an application for assistance from the risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement Iowa Code section 426B.5, subsection 2.

**441—25.67 to 25.70** Reserved.

DIVISION VI  
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

PREAMBLE

These rules provide for use of an appropriation from the tobacco settlement fund to establish a risk pool fund which may be used by counties with limited county mental health, mental retardation and developmental disabilities services funds to pay for increased compensation of the service staff of eligible purchase of service (POS) providers and establish the requirements for counties for receiving and repaying the funding. Implementation of the rate increases contemplated by the tobacco settlement fund in a timely manner will require cooperation among all eligible counties and providers.

**441—25.71(78GA,ch1221) Definitions.**

"Adjusted actual cost" means a POS provider's cost as computed using the financial and statistical report for the provider's fiscal year which ended during the state fiscal year beginning July 1, 1998 (state fiscal year 1999), as adjusted by multiplying those actual costs by 103.4 percent or the percentage

adopted by the risk pool board in accordance with 2000 Iowa Acts, chapter 1221, section 3, subsection 3, paragraph “c.”

“*Department*” means the Iowa department of human services.

“*Division*” means the mental health and developmental disabilities division of the department of human services.

“*Financial and statistical report*” means a report prepared by a provider and submitted to host counties that is prepared in accordance with department rules for cost determination set forth in 441—Chapter 150.

“*Host county*” means the county in which the primary offices of a POS provider are located. However, if a POS provider operates separate programs in more than one county, “host county” means each county in which a separate program is operated.

“*Purchase of service provider*” or “*POS provider*” means a provider of sheltered work, work activity, supported employment, job placement, enclave services, adult day care, transportation, supported community living services, or adult residential services paid by a county from the county’s services fund created in Iowa Code section 331.424A under a state purchase of service or county contract.

“*Risk pool board*” means that board established by Iowa Code section 426B.5, subsection 3.

“*Separate program*” means a POS service operated in a county other than the county in which the provider’s home office is located and for which the provider allocates costs separately from similar programs located in the county where the provider’s home office is located.

“*Services fund*” means the fund defined in Iowa Code section 331.424A.

“*Tobacco settlement fund loan*” or “*TSF loan*” means the tobacco settlement fund risk pool funds a county received in a fiscal year in which the county did not levy the maximum amount allowed for the county’s mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A. The repayment amount shall be limited to the amount by which the actual amount levied was less than the maximum amount allowed.

**441—25.72(78GA,ch1221) Risk pool board.** The risk pool board is organized and shall take action and keep minutes and records as set out in rule 441—25.62(426B).

A risk pool board member cannot be a part of any presentation to the board of that board member’s county’s application for tobacco settlement fund risk pool funds nor can the board member be a part of any action pertaining to that application. If a risk pool board member is employed by or is a board member of a POS provider whose increases in compensation caused the host county to apply to the fund, the board member cannot be a part of any presentation to the board nor can the board member be a part of any action pertaining to that application.

**441—25.73(78GA,ch1221) Rate-setting process.** For services provided on or after July 1, 2000, each county shall increase its reimbursement rates for each program to the lesser of the adjusted actual cost or 105 percent of the rate paid for services provided on June 30, 2000.

**25.73(1) Financial and statistical report.** Each provider of POS services shall submit a financial and statistical report to each host county for each program that the provider operates within that county. These reports shall include actual costs for each separate program for the provider’s fiscal year that ended during state fiscal year 1999 and state fiscal year 2000. These reports shall be submitted to the central point of coordination (CPC) administrator of the host county or counties no later than August 15, 2000.

**25.73(2) Rate determination.** The CPC administrator in each host county shall receive and review provider financial and statistical reports for each separate program for which that county is the host county. If the host county determines that all or part of the provider’s increase in costs is attributable to increases in service staff compensation and that the adjusted actual cost is more than the rate paid by the county on June 30, 2000, the CPC administrator shall notify the provider in writing of the new rate for each program no later than September 1, 2000.

If a rate paid for services provided on June 30, 2000, exceeds the adjusted actual cost, the county shall not be required to adjust the rate for services provided on or after July 1, 2000.

The provider shall, no later than September 11, 2000, send to the CPC administrator of any other counties with consumers in those programs a copy of the rate determination signed by the CPC administrator of the host county. A county may delay payment of the reimbursement rate established pursuant to this subrule until the risk pool board has completed action as to adopting or not adopting a different percentage for the definition of adjusted actual cost, provided however that any increased rates required by 2000 Iowa Acts, chapter 1221, section 3, subsection 2, paragraph "c," shall be paid retroactively for all services provided on or after July 1, 2000.

**25.73(3) Exemptions.**

*a.* A POS provider that has negotiated a reimbursement rate increase with a host county as of July 1, 2000, has the option of exemption from the provisions of these rules. However, a county shall not be eligible to receive tobacco settlement funds for any rates established outside of the process established in these rules.

*b.* Nothing in these rules precludes a county from increasing reimbursement rates of POS providers by an amount that is greater than that specified in these rules. However, a county shall not be eligible for tobacco settlement funds for the amount of any rate increase in excess of the amount established pursuant to these rules.

**441—25.74(78GA,ch1221) Application process.**

**25.74(1) Who may apply.** If a county determines that payment of POS provider rates in accordance with these rules will cause the county to expend more funds in FY2001 than budgeted for POS services, the county may apply for assistance from the tobacco settlement fund. However, any fiscal year 2000 projected accrual basis fund balances in excess of 25 percent of fiscal year 2000 services fund gross expenditures will reduce the amount for which a county is eligible. In considering the cost of implementing these provisions, a county shall not include the cost of rate increases granted to any providers who fail to complete financial and statistical reports as provided in these rules.

**25.74(2) How to apply.** The county shall send the original and 15 copies of Form 470-3768, Tobacco Settlement Fund Risk Pool Application, to the division. The division must receive the application no later than 4:30 p.m. on September 25, 2000. Facsimiles and electronic mail are not acceptable. The application shall be signed and dated by the chairperson of the county board of supervisors, the county auditor, and the CPC administrator. Staff of the division shall notify each county of receipt of the county's application.

**25.74(3) Request for additional information.** Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county by October 5, 2000, and request the information needed to complete the application. The county shall submit the required information by October 16, 2000.

**441—25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding.**

**25.75(1) Review of applications.** The risk pool board shall review all of the applications from counties for assistance from the tobacco settlement fund. If the total amount requested from the tobacco settlement fund does not exceed \$2 million, eligible counties shall be awarded funding pursuant to this division. The risk pool board shall determine for each county whether any or all of the assistance granted to that county is a TSF loan.

**25.75(2) Notice of decision.** The risk pool board shall notify the chair of the applying county's board of supervisors of the board's action no later than November 3, 2000. Copies shall be sent to the county auditor and the CPC administrator.

**25.75(3) Distribution of funds.** The total amount of the risk pool shall be limited to \$2 million. If the total dollar amount of the eligible applications exceeds the available pool, the risk pool board shall revise the percentage adjustment to actual cost to arrive at adjusted actual cost as defined in this division and prorate funding to the eligible counties. If it becomes necessary to revise the percentage adjustment used to determine adjusted actual cost, the risk pool board shall determine if applicant counties remain eligible under this program.



**25.75(4) Notification of adjustment.** If the risk pool board rolls back the percentage adjustment used to determine adjusted actual cost, the risk pool board shall notify the chair of the board of supervisors of all counties, and copies shall be sent to the county auditor and the CPC administrator of each county. Each host county shall recalculate the reimbursement rate under this division using the revised adjusted actual cost percentage and notify each provider in writing of the revised rate within 30 days of receiving notice of the percentage adjustment. The provider shall, within 30 days of receipt of notice, send to the CPC administrator of any other counties with consumers in those programs a copy of the revised rate determination signed by the CPC administrator of the host county.

**441—25.76(78GA,ch1221) Repayment provisions.**

**25.76(1) Required repayment.** Counties shall be required to repay TSF loans by January 1, 2002. Repayments shall be credited to the tobacco settlement fund.

**25.76(2) Notification to county.** In the notice of decision provided pursuant to these rules, the chairperson of the risk pool board shall notify each county of the portion, if any, of the assistance that is considered a TSF loan. If a county fails to reimburse the tobacco settlement fund by January 1, 2002, the board may request a revenue offset through the department of revenue. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the CPC administrator of the county.

**441—25.77(78GA,ch1221) Appeals.** The risk pool board may accept or reject an application for assistance from the tobacco settlement fund risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement 2000 Iowa Acts, chapter 1221, section 3, as amended by chapter 1232, section 4.

**441—25.78 to 25.80** Reserved.

DIVISION VII

**441—25.81(225C) Waiver request.** Rescinded **ARC 4610C**, IAB 8/14/19, effective 9/18/19.

**441—25.82 to 25.90** Reserved

DIVISION VIII

**441—25.91(331) Exemption from joining into mental health and disability services region.** Rescinded **ARC 4207C**, IAB 1/2/19, effective 3/1/19.

**441—25.92 to 25.94** Reserved.

DIVISION IX

DATA SUBMISSION TO DETERMINE MEDICAID OFFSET FOR COUNTIES

PREAMBLE

These rules define the department's standards for the submission of county mental health and disability services expenditure data so that the department can calculate the Medicaid offset for each county consistent with 2014 Iowa Acts, House File 2473, section 82.

[**ARC 1671C**, IAB 10/15/14, effective 9/25/14]

**441—25.95(426B) Definitions.**

“*Department*” means the Iowa department of human services.

“*Medicaid offset amount*” means the amount resulting from the calculations described in Iowa Code section 426B.3 as amended by 2014 Iowa Acts, House File 2463, section 82(5) “d.”

“*Uniform chart of accounts for Iowa county governments*” means the set of codes used by counties to organize and delineate revenues and expenditures. The codes related to mental health and disability services expenditures identify diagnosis and types of services.  
[ARC 1671C, IAB 10/15/14, effective 9/25/14]

**441—25.96(426B) Data to determine Medicaid offset.** Each county must submit to the department a report that provides the county mental health and disability services data needed to calculate the Medicaid offset for the county.

**25.96(1) Data required.** Each county is required to submit expenditure data as specified by the department based on the agreement by the department and representatives of the mental health and disability services regions consistent with the requirements of Iowa Code section 426B.3 as amended by 2014 Iowa Acts, House File 2463, section 82(5) “b.”

**25.96(2) Submission of mental health and disability services data.**

a. Counties must submit the required data to the department by 4:30 p.m. on September 19, 2014, consistent with data submissions as required in subrule 25.41(3).

b. If a county fails to submit data within the required time frame or a county submits data that is demonstrably inaccurate, the department will use a pro-rata methodology to determine the county’s Medicaid offset using data submitted by other counties.

[ARC 1671C, IAB 10/15/14, effective 9/25/14]

These rules are intended to implement Iowa Code section 225C.6 and 2014 Iowa Acts, House File 2463, section 82.

**441—25.97 to 25.100** Reserved.

DIVISION X  
MENTAL HEALTH ADVOCATES

PREAMBLE

This division establishes definitions, appointment and qualifications, assignment, responsibilities of the advocate and the county, data collection requirements, and quality assurance for mental health advocate services under Iowa Code chapter 229.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

**441—25.101(229) Definitions.**

“*Advocate*” means mental health advocate as defined in Iowa Code section 229.1.

“*Conflict of interest*” means any activity that interferes or gives the appearance of interference with the exercise of professional discretion and impartial judgment.

“*County of residence*” means the same as defined in Iowa Code section 331.394.

“*County of venue*” means the county in which the Iowa Code chapter 229 commitment was filed pursuant to Iowa Code section 229.44.

“*County where the individual is located*” means the individual’s county of residence as defined in Iowa Code section 331.394, or if the individual has been ordered to receive treatment services under an Iowa Code chapter 229 commitment and is placed in a residential or other treatment facility.

“*Individual*” means the respondent who is receiving mental health advocate services under Iowa Code chapter 229.

“*Judicial district*” means the same as defined in Iowa Code section 602.6107.

“*Mental health and disability services region*” means the same as defined in Iowa Code section 331.389.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

**441—25.102(229) Advocate appointment and qualifications.** The board of supervisors of each county shall appoint a person to act as an advocate representing the interests of individuals involuntarily hospitalized by the court under Iowa Code chapter 229. The advocate is hired by the board of supervisors and employed by the county.

**25.102(1)** A person may be appointed and employed or contracted with as the advocate by one county or by multiple counties. Advocates may be appointed for counties in more than one judicial district or more than one mental health and disability services region.

**25.102(2)** Qualifications.

*a.* The advocate shall meet the following qualifications:

(1) Possess a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to persons with mental illness; or

(2) Hold an Iowa license to practice as a registered nurse and have at least three years of experience in delivery of services to persons with mental illness.

*b.* A person employed as an advocate on or before July 1, 2015, who does not meet the requirements of subparagraph 25.102(2) "a"(1) or (2) shall be considered to meet those requirements so long as the person is continuously appointed as an advocate in the employing county.

*c.* A person employed as an advocate must pass criminal background, sex offender registry, and child and dependent adult abuse registry checks before hire.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

**441—25.103(229) Advocate assignment.** The committing court shall assign the advocate from the county where the individual is located.

**25.103(1)** If the advocate assigned cannot serve the individual in an effective and efficient manner, the advocate may request another advocate to perform advocate duties on the individual's behalf. In the event that another advocate can better represent the individual on a longer term basis, the advocate shall request that the court transfer the individual to another advocate.

**25.103(2)** When a conflict of interest is identified between an advocate and an individual, the court and the advocate's county of employment shall be notified and an alternative advocate shall be assigned. The advocate's direct supervisor is responsible to monitor and ensure that the advocate does not have a conflict of interest. In instances when dual or multiple relationships are unavoidable, advocates should take steps to protect individuals and are responsible for setting clear, appropriate, and culturally sensitive boundaries. Advocates who anticipate a conflict of interest among the individuals receiving services should clarify the advocate's role with the parties involved and take appropriate action to minimize any conflict of interest.

**25.103(3)** When the advocate assigned is not the advocate from the individual's county of residence, the advocate's county of employment may seek reimbursement from the region in which the individual's county of residence is located as outlined in Iowa Code section 229.19(1) "b."

**25.103(4)** An advocate shall only be assigned to a child 17 years of age or under when the child is not represented by an attorney due to an existing child in need of assistance (CINA) or other juvenile court action pursuant to the Iowa Code.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

**441—25.104(229) Advocate responsibilities.** The minimum duties of the advocate are outlined in Iowa Code section 229.19. The role of the advocate is to ensure that the rights of the individual are upheld.

**25.104(1)** The advocate shall be readily accessible to communication from the individual and shall initiate contact within 5 days of the individual's commitment. The advocate shall inform the individual regarding the role of the advocate.

**25.104(2)** The advocate shall meet the individual in person within 15 days of the individual's commitment. The advocate shall present the county grievance procedure process, in writing, to the individual. The presentation shall include the county grievance procedure and contact information and the contact information for the citizens' aide/ombudsman. The advocate shall inform the individual about the mental health crisis services that are available.

**25.104(3)** The advocate shall review each report submitted to the court and communicate with the individual's medical and treatment team. Advocates shall abide by all federal, state, and local confidentiality laws.

**25.104(4)** The advocate shall file with the court Iowa Ct. R. 12.36—Form 30, quarterly reports for each individual assigned to the advocate. The report shall state the actions taken with the individual and amount of time spent on behalf of the individual.

**25.104(5)** The advocate shall maintain an organized confidential and secure file for each individual served. The file shall contain but not be limited to:

- a. Copies of quarterly reports submitted to the court.
- b. Copies of correspondence sent to and received from the individual, family members, providers and others.
- c. Releases of information.
- d. Case notes describing the date, time and type of contact with the individuals or others and a brief narrative summary of the content or outcome of the contact.
- e. Documents filed with the court electronically shall be considered as part of the individual's file.

**25.104(6)** The advocate shall register as provided in Iowa Ct. R. 16.305(1) to participate in the court's electronic document management system and shall submit all documents to be filed with the court electronically. The documents will be stored as electronic records that are retrievable and readable through the electronic document management system.

**25.104(7)** The advocate, as an employee of the county, shall comply with all county policies and procedures, including but not limited to hiring, supervision, grievance procedures, and training.

**25.104(8)** All advocate records are the property of the county, which is responsible for the provision of confidential storage, transfer, and destruction of client files, including those maintained on electronic and digital devices, with access limited according to the county's policy on confidentiality as described in subrule 25.105(6).

**25.104(9)** The advocate may attend the hospitalization hearing of an individual represented by an attorney; however, payment for the advocate's attendance is at the discretion of the county of employment.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

**441—25.105(229) County responsibilities.** As the employer of the advocate, the county shall provide qualified staff to support and facilitate the provision of quality advocate services. The county shall:

**25.105(1)** Assign a single supervisor, a single contract manager, or the county board of supervisors as the supervising entity to carry out responsibilities in this chapter.

**25.105(2)** Have a job description in the personnel file of the advocate that clearly defines the advocate's responsibilities and qualifications as defined in Iowa Code section 229.19 and in rule 441—25.104(229).

**25.105(3)** Have a process to verify, within 90 days of the advocate's hire, qualification of the advocate, including degrees and certifications obtained from a primary source.

**25.105(4)** Provide to the advocate training and education relevant to the position, including but not limited to overview of mental health diagnosis and treatment, the mental health and disability services delivery system, confidentiality, individual rights, professional conduct, the role of advocacy and service coordination within an interdisciplinary team, Iowa Code and administrative rules, and court procedures.

**25.105(5)** Provide approved training on child and dependent adult abuse reporter requirements.

**25.105(6)** Provide to any employee with access to individuals' files training on state and federal laws regarding nondisclosure and confidentiality of client protected health information during and after employment and maintain in the personnel files a signed document indicating the employee's awareness of the county's policy on confidentiality.

**25.105(7)** Complete criminal background, sex offender registry and child and dependent adult abuse registry checks before employment of the advocate. Any person who does not pass these checks is prohibited from being hired, or continuing to serve, as an advocate.

**25.105(8)** Provide advocate staff to cover the county's caseload at all times, according to, but not limited to, each county's unique number of individuals assigned to the advocate, travel required, types of settings where the individuals reside, services available and extended staff absences.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

**441—25.106(229) Data collection requirements.**

**25.106(1)** Beginning in 2016 and by December 1 each year, each county shall submit to the department of human services data regarding each individual who received advocate services during the previous state fiscal year.

**25.106(2)** As defined in rule 441—25.41(331), the data to be submitted are as follows:

- a. Basic information about the individual, including a unique identifier and county of residence.
- b. Demographic information, including the individual's date of birth, sex, ethnicity, education, and diagnosis made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA).
- c. Commitment information, including the date of the individual's initial commitment, type of commitment order, whether a juvenile or adult case, date of commitment and name of treatment facility the individual is committed to, any subsequent changes in treatment facility, and date commitment is terminated.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; see Delay note at end of chapter]

**441—25.107(229) Quality assurance system.** The county shall implement a quality assurance system which:

1. Annually measures and assesses advocates' activities and services.
2. Gathers feedback from stakeholders including individuals using advocate services, family members, court staff, service provider staff, and regional staff regarding advocate services.
3. Implements an internal review of individual records.
4. Identifies areas in need of improvement.
5. Develops a plan to address the areas in need of improvement.
6. Implements the plan and documents the results.

[ARC 2438C, IAB 3/16/16, effective 5/1/16]

These rules are intended to implement Iowa Code chapter 229.

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<sup>1</sup> Two ARCs

<sup>2</sup> May 1, 2016, effective date of 25.106 (ARC 2438C) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 8, 2016. At its meeting held June 14, 2016, the Committee delayed the effective date of 25.106 until the adjournment of the 2017 Session of the General Assembly.