

House File 2635 - Reprinted

HOUSE FILE 2635
BY COMMITTEE ON HEALTH AND
HUMAN SERVICES

(SUCCESSOR TO HF 2438)

(As Amended and Passed by the House March 3, 2026)

A BILL FOR

1 An Act relating to health carriers standards of conduct;
2 utilization review organizations, artificial intelligence,
3 audits, and prior authorizations; certificate of need
4 processes; and including applicability provisions.
5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

HEALTH INSURANCE TRADE PRACTICES

Section 1. Section 514F.8, Code 2026, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. A utilization review organization may use an artificial intelligence-based algorithm or system to provide an initial review of a request for prior authorization, except that, for a prior authorization request for a health care service based on medical necessity, a utilization review organization shall not use an artificial intelligence-based algorithm or system as the sole basis for the utilization review organization's decision to deny, delay, or downgrade the prior authorization request.

Sec. 2. NEW SECTION. 514F.8C Utilization review organizations — audits.

1. As used in this section, unless the context otherwise requires:

a. "Audit" means a review, investigation, or request for additional documentation by a utilization review organization before or after issuing payment on a claim to a health care provider.

b. "Commissioner" means the commissioner of insurance.

c. "Health care provider" means the same as defined in section 514F.8.

d. "Health carrier" means the same as defined in Section 514F.8.

e. "Utilization review organization" means the same as defined in section 514F.8.

2. *a.* A utilization review organization that conducts an audit shall notify the health care provider that submitted the claim of the initiation of the audit no later than fifteen calendar days after the date the utilization review organization selects the claim for audit.

b. A utilization review organization shall complete an audit of a claim and issue a determination on the claim to the health

1 care provider that submitted the claim no later than forty-five
2 calendar days after the date that the utilization review
3 organization receives all requested documentation regarding the
4 claim from the health care provider.

5 *c.* A health care provider that submitted a claim that is
6 the subject of an audit by a utilization review organization
7 that receives an adverse determination regarding the claim may
8 appeal the adverse determination no later than thirty calendar
9 days after the date the health care provider receives the audit
10 determination.

11 *d.* A utilization review organization shall consider an
12 appeal under paragraph "*c*" and issue a final determination
13 on the claim that is the subject of the appeal no later than
14 thirty calendar days after the date the utilization review
15 organization receives notice of the appeal.

16 *e.* If, after a hearing, the commissioner finds that a
17 utilization review organization has violated this subsection,
18 the claim shall be approved by the utilization review
19 organization and promptly paid, including interest at the rate
20 of ten percent per annum.

21 3. *a.* This section applies to the following classes of
22 third-party payment provider contracts, policies, or plans
23 delivered, issued for delivery, continued, or renewed in this
24 state on or after January 1, 2027:

25 (1) Individual or group accident and sickness insurance
26 providing coverage on an expense-incurred basis.

27 (2) An individual or group hospital or medical service
28 contract issued pursuant to chapter 509, 514, or 514A.

29 (3) An individual or group health maintenance organization
30 contract regulated under chapter 514B.

31 (4) A plan established for public employees pursuant to
32 chapter 509A.

33 *b.* This section shall not apply to accident-only, specified
34 disease, short-term hospital or medical, hospital confinement
35 indemnity, credit, dental, vision, Medicare supplement,

1 long-term care, basic hospital and medical-surgical expense
2 coverage as defined by the commissioner of insurance,
3 disability income insurance coverage, coverage issued as a
4 supplement to liability insurance, workers' compensation or
5 similar insurance, or automobile medical payment insurance.

6 4. The commissioner may adopt rules pursuant to chapter 17A
7 to administer and enforce this section.

8 5. a. This section shall apply to an audit initiated on or
9 after January 1, 2027.

10 b. This section shall not apply to a claim that is under
11 active fraud investigation by a state or federal authority.

12 c. This section shall not apply to a federal program where
13 audits are mandated by federal law.

14 Sec. 3. NEW SECTION. 514F.8D Health carriers — standards
15 of conduct.

16 1. As used in this section, unless the context otherwise
17 requires:

18 a. "Health care provider" means the same as defined in
19 section 514J.102.

20 b. "Health carrier" means the same as defined in section
21 514F.8.

22 2. A health carrier shall not impose on a health care
23 provider, directly or indirectly, any financial penalty,
24 reimbursement reduction, or administrative fee, or terminate a
25 health care provider's participation in the health carrier's
26 network, based on the health care provider's referral to, or
27 affiliation with, an out-of-network health care provider.

28 3. A health carrier shall not interfere with, or participate
29 in any capacity in, a health care provider's decisions
30 regarding staffing and referrals, except as otherwise provided
31 by law.

32 4. A health carrier shall not offer, attempt to enforce,
33 or enforce an agreement, or an amendment to an agreement, with
34 a health care provider without providing an opportunity for
35 negotiation.

1 5. The commissioner may adopt rules pursuant to chapter 17A
2 to administer and enforce this section.

3 DIVISION II

4 PRIOR AUTHORIZATIONS

5 Sec. 4. NEW SECTION. 514F.8A Prior authorizations — peer
6 review.

7 1. For purposes of this section, unless the context
8 otherwise requires:

9 a. "*Clinical peer*" means a health care professional that
10 meets all of the following requirements:

11 (1) The health care professional practices in the same or
12 similar specialty as the health care provider that requested
13 a prior authorization.

14 (2) The health care professional has experience managing
15 the specific medical condition or administering the health care
16 service that is the subject of the prior authorization request.

17 (3) The health care professional is employed by or
18 contracted with the utilization review organization or health
19 carrier to which a health care provider submitted a request for
20 prior authorization.

21 b. "*Covered person*" means the same as defined in section
22 514F.8.

23 c. "*Downgrade*" means a decision by a utilization review
24 organization to change an expedited or urgent request for prior
25 authorization to a standard determination, or otherwise modify
26 a health care service that is the subject of a request for
27 prior authorization to a lower-level health care service.

28 d. "*Health care professional*" means the same as defined in
29 section 514J.102.

30 e. "*Health care provider*" means the same as defined in
31 section 514F.8.

32 f. "*Health care services*" means the same as defined in
33 section 514F.8.

34 g. "*Health carrier*" means the same as defined in section
35 514F.8.

1 *h. "Physician"* means a doctor of medicine and surgery, or
2 a doctor of osteopathic medicine and surgery, licensed under
3 chapter 148.

4 *i. "Prior authorization"* means the same as defined in
5 section 514F.8.

6 *j. "Qualified reviewer"* means a physician that meets all of
7 the following requirements:

8 (1) The physician practices in the same or a similar
9 specialty as the health care provider that requested a prior
10 authorization.

11 (2) The physician has the training and expertise to treat
12 the specific medical condition that is the subject of a
13 request for prior authorization, including sufficient knowledge
14 to determine whether the health care service that is the
15 subject of the request is medically necessary or clinically
16 appropriate.

17 (3) The physician is employed by or contracted with the
18 utilization review organization to which a health care provider
19 submitted a request for prior authorization.

20 *k. "Utilization review organization"* means the same as
21 defined in section 514F.8.

22 2. A utilization review organization shall not deny or
23 downgrade a request for prior authorization unless all of the
24 following requirements are met:

25 *a.* The decision to deny or downgrade the request is made by
26 either of the following:

27 (1) A qualified reviewer, if the health care provider
28 requesting prior authorization is a physician.

29 (2) A clinical peer, if the health care provider requesting
30 prior authorization is not a physician.

31 *b.* The utilization review organization provides the health
32 care provider that requested the prior authorization all of the
33 following:

34 (1) A written statement that cites the specific reasons
35 for the denial or downgrade, including any coverage criteria

1 or limits, or clinical criteria, that the utilization review
2 organization considered or that was the basis for the denial
3 or downgrade. The written statement must be signed by either
4 of the following:

5 (a) The qualified reviewer that made the denial or downgrade
6 determination if the health care provider that requested prior
7 authorization is a physician.

8 (b) The clinical peer that made the denial or downgrade
9 determination if the health care provider that requested prior
10 authorization is not a physician.

11 (2) A written explanation of the utilization review
12 organization's appeals process. The utilization review
13 organization shall also provide the written explanation to the
14 covered person for whom prior authorization was requested.

15 (3) A written attestation that is either of the following:

16 (a) If the health care provider that requested prior
17 authorization is a physician, a written attestation that
18 the qualified reviewer who made the denial or downgrade
19 determination practices in the same or a similar specialty as
20 the health care provider, and has the requisite training and
21 expertise to treat the medical condition that is the subject
22 of the request for prior authorization, including sufficient
23 knowledge to determine whether the health care service is
24 medically necessary or clinically appropriate. The attestation
25 shall include the qualified reviewer's name, national provider
26 identifier, state medical license number, board certifications,
27 specialty expertise, and educational background.

28 (b) If the health care provider that requested prior
29 authorization is not a physician, a written attestation
30 that the clinical peer who made the denial or downgrade
31 determination practices in the same or a similar specialty as
32 the health care provider, and the clinical peer has experience
33 managing the specific medical condition or administering
34 the health care service that is the subject of the request
35 for prior authorization. The attestation shall include the

1 clinical peer's name, national provider identifier, state
2 medical license number, board certifications, specialty
3 expertise, and educational background.

4 3. At the request of the requesting health care provider, a
5 utilization review organization that denies a request for prior
6 authorization shall, no later than seven business days after
7 the date that the utilization review organization notifies
8 the requesting health care provider of the denial, conduct a
9 consultation either in person or remotely, as follows:

10 a. Between the health care provider and a qualified reviewer
11 if the health care provider requesting prior authorization is a
12 physician.

13 b. Between the health care provider and a clinical peer if
14 the health care provider requesting prior authorization is not
15 a physician.

16 4. a. If a utilization review organization's decision to
17 deny or downgrade a request for prior authorization is appealed
18 by the requesting health care provider or covered person, the
19 appeal shall be conducted by either of the following:

20 (1) A qualified reviewer if the health care provider
21 requesting prior authorization is a physician.

22 (2) A clinical peer if the health care provider requesting
23 prior authorization is not a physician.

24 b. A qualified reviewer or clinical peer involved in the
25 initial denial or downgrade determination of a request for
26 prior authorization that is the subject of an appeal shall not
27 conduct the appeal.

28 c. When conducting an appeal of a request for prior
29 authorization, the qualified reviewer or clinical peer shall
30 consider the known clinical aspects of the health care services
31 under review, including but not limited to medical records
32 relevant to the covered person's medical condition who is
33 the subject of the health care services for which prior
34 authorization is requested, and any relevant medical literature
35 submitted by the health care provider as part of the appeal.

1 5. This section applies to requests for prior authorization
2 made on or after January 1, 2027.

3 6. *a.* This section applies to the following classes of
4 third-party payment provider contracts, policies, or plans
5 delivered, issued for delivery, continued, or renewed in this
6 state on or after January 1, 2027:

7 (1) Individual or group accident and sickness insurance
8 providing coverage on an expense-incurred basis.

9 (2) An individual or group hospital or medical service
10 contract issued pursuant to chapter 509, 514, or 514A.

11 (3) An individual or group health maintenance organization
12 contract regulated under chapter 514B.

13 (4) A plan established for public employees pursuant to
14 chapter 509A.

15 *b.* This section shall not apply to accident-only, specified
16 disease, short-term hospital or medical, hospital confinement
17 indemnity, credit, dental, vision, Medicare supplement,
18 long-term care, basic hospital and medical-surgical expense
19 coverage as defined by the commissioner of insurance,
20 disability income insurance coverage, coverage issued as a
21 supplement to liability insurance, workers' compensation or
22 similar insurance, or automobile medical payment insurance.

23 7. The commissioner of insurance may adopt rules pursuant to
24 chapter 17A to administer this section.

25 Sec. 5. NEW SECTION. 514F.8B Prior authorizations —
26 exemptions.

27 1. For purposes of this section:

28 *a.* "Covered person" means the same as defined in section
29 514F.8.

30 *b.* "Health benefit plan" means the same as defined in
31 section 514J.102.

32 *c.* "Health care professional" means the same as defined in
33 section 514J.102.

34 *d.* "Health carrier" means the same as defined in section
35 514F.8.

1 *e.* "Prior authorization" means the same as defined in
2 section 514F.8.

3 *f.* "Utilization review" means the same as defined in section
4 514F.4, subsection 3.

5 2. A health carrier shall not require prior authorization
6 for, or impose additional utilization review requirements on, a
7 covered person for any of the following:

8 *a.* A cancer-related screening if the cancer-related
9 screening is recommended by the covered person's health care
10 professional based on the most recently updated national
11 comprehensive cancer network clinical practice guidelines in
12 oncology which are designated as category 2A or lower.

13 *b.* Diagnosis and treatment of an emergency medical condition
14 that develops or becomes evident in a covered person while
15 the covered person is receiving inpatient care that meets
16 inpatient care standards, if the emergency medical condition
17 is reasonably determined by a health care professional to be a
18 life-threatening condition unless the covered person receives
19 immediate assessment and treatment.

20 3. This section applies to all of the following:

21 *a.* Health benefit plans delivered, issued for delivery,
22 continued, or renewed in this state on or after January 1,
23 2027.

24 *b.* Requests for prior authorization for a cancer-related
25 screening, if the screening is recommended by the covered
26 person's health care professional based on the most recently
27 updated national comprehensive cancer network clinical practice
28 guidelines in oncology designated as category 2A or lower, and
29 is made on or after January 1, 2027.

30 *c.* Requests for prior authorization for the diagnosis and
31 treatment of an emergency medical condition that develops or
32 becomes evident in a covered person while the covered person is
33 receiving inpatient care that meets inpatient care standards,
34 if the emergency medical condition is reasonably determined by
35 a health care professional to be a life-threatening condition

1 unless the covered person receives immediate assessment and
2 treatment if the request is made on or after January 1, 2027.

3 4. a. This section applies to the following classes of
4 third-party payment provider contracts, policies, or plans
5 delivered, issued for delivery, continued, or renewed in this
6 state on or after January 1, 2027:

7 (1) Individual or group accident and sickness insurance
8 providing coverage on an expense-incurred basis.

9 (2) An individual or group hospital or medical service
10 contract issued pursuant to chapter 509, 514, or 514A.

11 (3) An individual or group health maintenance organization
12 contract regulated under chapter 514B.

13 (4) A plan established for public employees pursuant to
14 chapter 509A.

15 b. This section shall not apply to accident-only, specified
16 disease, short-term hospital or medical, hospital confinement
17 indemnity, credit, dental, vision, Medicare supplement,
18 long-term care, basic hospital and medical-surgical expense
19 coverage as defined by the commissioner of insurance,
20 disability income insurance coverage, coverage issued as a
21 supplement to liability insurance, workers' compensation or
22 similar insurance, or automobile medical payment insurance.

23 5. The commissioner of insurance may adopt rules pursuant to
24 chapter 17A to administer this section.

25 Sec. 6. NEW SECTION. 514F.8E Enforcement.

26 The remedy for noncompliance with section 514F.8, 514F.8A,
27 514F.8B, 514F.8C, or 514F.8D shall be those remedies authorized
28 by chapters 505 and 507B pursuant to the procedures set forth
29 in sections 507B.6, 507B.7, and 507B.8. Upon a finding of
30 a pattern or practice of noncompliance with sections 514F.8,
31 514F.8A, 514F.8B, 514F.8C, or 514F.8D, the commissioner of
32 insurance may also suspend a utilization review organization's
33 authority to conduct utilization review.

34 DIVISION III

35 PRIOR AUTHORIZATIONS — MEDICAL ASSISTANCE PROGRAM

1 Sec. 7. NEW SECTION. **249A.5 Prior authorization —**
2 **exemptions.**

3 1. For purposes of this section, unless the context
4 otherwise requires:

5 *a. "Emergency medical condition"* means the same as defined
6 in 42 C.F.R. §438.114.

7 *b. "Managed care organization"* means an entity acting
8 pursuant to a contract with the department to administer the
9 medical assistance program.

10 *c. "Prior authorization"* means any process used by the
11 department or a managed care organization to determine if,
12 before a health care service is furnished to a recipient, the
13 service is covered or medically necessary.

14 *d. "Utilization review"* means a set of formal techniques
15 used to monitor or evaluate the medical necessity,
16 appropriateness, or efficiency of a health care service.

17 2. The department, or a managed care organization, shall
18 not require prior authorization for, or impose additional
19 utilization review requirements on, a recipient for any of the
20 following:

21 *a.* A cancer-related screening recommended for the recipient
22 by the recipient's provider in accordance with the most
23 recently updated national comprehensive cancer network clinical
24 practice guidelines in oncology which are designated as
25 category 2A or lower.

26 *b.* The diagnosis and treatment of an emergency medical
27 condition that develops or becomes evident in a recipient
28 while the recipient is receiving inpatient care that
29 meets inpatient care standards, if the emergency medical
30 condition is reasonably determined by a provider to present a
31 life-threatening risk unless the recipient receives immediate
32 assessment and treatment.

33 3. This section applies to all of the following:

34 *a.* All contracts between the department and a managed
35 care organization that are delivered, issued for delivery,

1 continued, extended, or renewed on or after January 1, 2027.

2 *b.* All requests for prior authorization made on or after
3 January 1, 2027.

4 4. The department may adopt rules pursuant to chapter 17A to
5 administer this section.

6 Sec. 8. NEW SECTION. 514I.13 Prior authorizations —
7 exemptions.

8 1. For purposes of this section:

9 *a.* "*Emergency medical condition*" means the same as defined
10 in 42 C.F.R. §438.114.

11 *b.* "*Health care professional*" means a person licensed or
12 certified under the laws of this state to provide health care
13 services to an eligible child.

14 *c.* "*Managed care organization*" means an entity acting
15 pursuant to a contract with the department to administer the
16 Hawki program.

17 *d.* "*Prior authorization*" means any process used by the
18 department or a managed care organization to determine if,
19 before a health care service is furnished to an eligible child,
20 the service is covered or medically necessary.

21 *e.* "*Utilization review*" means a set of formal techniques
22 used to monitor or evaluate the medical necessity,
23 appropriateness, or efficiency of a health care service.

24 2. The department, or a managed care organization, shall
25 not require prior authorization for, or impose additional
26 utilization review requirements on, an eligible child for any
27 of the following:

28 *a.* A cancer-related screening recommended for the eligible
29 child by the eligible child's health care professional
30 in accordance with the most recently updated national
31 comprehensive cancer network clinical practice guidelines in
32 oncology which are designated as category 2A or lower.

33 *b.* The diagnosis and treatment of an emergency medical
34 condition that develops or becomes evident in an eligible child
35 while the eligible child is receiving inpatient care that meets

1 inpatient care standards, if the emergency medical condition is
2 reasonably determined by a health care professional to present
3 a life-threatening risk unless the eligible child receives
4 immediate assessment and treatment.

5 3. This section applies to all of the following:

6 a. All contracts between the department and a managed
7 care organization that are delivered, issued for delivery,
8 continued, extended, or renewed on or after January 1, 2027.

9 b. All requests for prior authorizations made on or after
10 January 1, 2027.

11 4. The department may adopt rules pursuant to chapter 17A to
12 administer this section.

13 DIVISION IV

14 CERTIFICATES OF NEED

15 Sec. 9. Section 135.61, subsection 1, paragraphs d and f,
16 Code 2026, are amended by striking the paragraphs.

17 Sec. 10. Section 135.61, subsection 12, paragraph e, Code
18 2026, is amended by striking the paragraph.

19 Sec. 11. Section 135.61, subsection 16, Code 2026, is
20 amended to read as follows:

21 16. *"New institutional health service"* or *"changed*
22 *institutional health service"* means any of the following:

23 a. (1) The construction, development, or other
24 establishment of a new institutional health facility regardless
25 of ownership if completing the construction, development, or
26 other establishment requires more than the following amount:

27 (a) Beginning on or after January 1, 2027, and before
28 December 31, 2031, four million dollars.

29 (b) Beginning on or after January 1, 2032, and before
30 December 31, 2036, four million five hundred thousand dollars.

31 (c) Beginning on or after January 1, 2037, five million
32 dollars.

33 (2) If the new institutional health facility involves
34 the use of a leased building, the market value of the leased
35 building shall be used when calculating the value of completing

1 construction, development, or other establishment under
2 subparagraph (1).

3 *b.* Relocation of an institutional health facility.

4 *c.* ~~Any A~~ capital expenditure, lease, or donation by ~~or on~~
5 ~~behalf of~~ an institutional health facility in excess of ~~one~~
6 ~~million five hundred thousand dollars~~ the following amount
7 within a consecutive twelve-month period:

8 (1) Beginning on or after January 1, 2027, and before
9 December 31, 2031, four million dollars.

10 (2) Beginning on or after January 1, 2032, and before
11 December 31, 2036, four million five hundred thousand dollars.

12 (3) Beginning on or after January 1, 2037, five million
13 dollars.

14 *d.* A permanent change in the bed capacity, as determined
15 by the department, of an institutional health facility. For
16 purposes of this paragraph, a change is permanent if it is
17 intended to be effective for one year or more.

18 ~~*e.* Any expenditure in excess of five hundred thousand~~
19 ~~dollars by or on behalf of an institutional health facility for~~
20 ~~health services which are or will be offered in or through an~~
21 ~~institutional health facility at a specific time but which were~~
22 ~~not offered on a regular basis in or through that institutional~~
23 ~~health facility within the twelve-month period prior to that~~
24 ~~time.~~

25 ~~*f.* The deletion of one or more health services, previously~~
26 ~~offered on a regular basis by an institutional health facility~~
27 ~~or health maintenance organization or the relocation of one or~~
28 ~~more health services from one physical facility to another.~~

29 ~~*g.* Any acquisition by or on behalf of a health care provider~~
30 ~~or a group of health care providers of any piece of replacement~~
31 ~~equipment with a value in excess of one million five hundred~~
32 ~~thousand dollars, whether acquired by purchase, lease, or~~
33 ~~donation.~~

34 ~~*h.*~~ *e.* (1) Any acquisition by or on behalf of a health
35 care provider or group of health care providers of any piece of

1 ~~equipment with a value in excess of one million five hundred~~
2 ~~thousand dollars,~~ whether acquired by purchase, lease, or
3 donation, which results in the offering or development of a
4 health service not previously provided that has a value in
5 excess of the following amount:

6 (a) Beginning on or after January 1, 2027, and before
7 December 31, 2031, four million dollars.

8 (b) Beginning on or after January 1, 2032, and before
9 December 31, 2036, four million five hundred thousand dollars.

10 (c) Beginning on or after January 1, 2037, five million
11 dollars.

12 (2) A mobile health service provided on a contract basis
13 is not considered to have been previously provided by a health
14 care provider or group of health care providers.

15 ~~i. Any acquisition by or on behalf of an institutional~~
16 ~~health facility or a health maintenance organization of any~~
17 ~~piece of replacement equipment with a value in excess of one~~
18 ~~million five hundred thousand dollars, whether acquired by~~
19 ~~purchase, lease, or donation.~~

20 ~~j. f. (1) Any acquisition by or on behalf of an~~
21 ~~institutional health facility or health maintenance~~
22 ~~organization of any piece of equipment with a value in excess~~
23 ~~of one million five hundred thousand dollars, whether acquired~~
24 ~~by purchase, lease, or donation, which results in the offering~~
25 ~~or development of a health service not previously provided that~~
26 ~~has a value in excess of the following amount:~~

27 (a) Beginning on or after January 1, 2027, and before
28 December 31, 2031, four million dollars.

29 (b) Beginning on or after January 1, 2032, and before
30 December 31, 2036, four million five hundred thousand dollars.

31 (c) Beginning on or after January 1, 2037, five million
32 dollars.

33 (2) A mobile health service provided on a contract basis
34 is not considered to have been previously provided by an
35 institutional health facility.

1 ~~k. Any air transportation service for transportation of~~
2 ~~patients or medical personnel offered through an institutional~~
3 ~~health facility at a specific time but which was not offered~~
4 ~~on a regular basis in or through that institutional health~~
5 ~~facility within the twelve-month period prior to the specific~~
6 ~~time.~~

7 ~~i. g. Any A mobile health service with a value in excess of~~
8 ~~one four million five hundred thousand dollars.~~

9 ~~m. Any of the following:~~

10 ~~(1) Cardiac catheterization service.~~

11 ~~(2) Open heart surgical service.~~

12 ~~(3) Organ transplantation service.~~

13 ~~(4) Radiation therapy service applying ionizing radiation~~
14 ~~for the treatment of malignant disease using megavoltage~~
15 ~~external beam equipment.~~

16 Sec. 12. Section 135.62, subsection 1, Code 2026, is amended
17 to read as follows:

18 1. a. A new institutional health service or changed
19 institutional health service shall not be offered or developed
20 in this state without prior application to the department
21 for, and receipt of, a certificate of need, pursuant to this
22 subchapter.

23 b. The application shall be made ~~upon~~ on forms furnished or
24 prescribed by the department and shall contain ~~such~~ information
25 as required by the department ~~may require under this subchapter~~
26 by rule adopted pursuant to chapter 17A.

27 c. (1) The application shall be accompanied by a fee
28 equivalent to three-tenths of one percent of the anticipated
29 cost of the project with a minimum fee of six hundred dollars
30 and a maximum fee of twenty-one thousand dollars. The fee
31 shall be remitted by the department to the treasurer of state,
32 ~~who shall place it for deposit~~ in the general fund of the
33 state. An applicant for a new institutional health service or
34 a changed institutional health service offered or developed by
35 an intermediate care facility for persons with an intellectual

1 disability or an intermediate care facility for persons with
2 mental illness, as each of those terms are defined in section
3 135C.1, shall not be required to pay the application fee.

4 (2) If an application is voluntarily withdrawn within
5 thirty calendar days after submission, seventy-five percent
6 of the application fee shall be refunded; ~~if the application~~
7 ~~is voluntarily withdrawn more than thirty but within sixty~~
8 ~~days after submission, fifty percent of the application fee~~
9 ~~shall be refunded; if the application is withdrawn voluntarily~~
10 ~~more than sixty days after submission, twenty-five percent of~~
11 ~~the application fee shall be refunded. Notwithstanding the~~
12 ~~required payment of an application fee under [this subsection](#),~~
13 ~~an applicant for a new institutional health service or a~~
14 ~~changed institutional health service offered or developed by~~
15 ~~an intermediate care facility for persons with an intellectual~~
16 ~~disability or an intermediate care facility for persons with~~
17 ~~mental illness as defined pursuant to [section 135C.1](#) is exempt~~
18 ~~from payment of the application fee.~~

19 Sec. 13. Section 135.62, subsection 2, paragraphs a and e,
20 Code 2026, are amended to read as follows:

21 a. Private offices and private clinics of an individual
22 physician, dentist, or other practitioner or group of
23 health care providers, except as provided by section 135.61,
24 subsection 16, paragraphs "g", "h", and "m" paragraph "e", and
25 section 135.61, subsections 2 and 18.

26 e. A health maintenance organization or combination of
27 health maintenance organizations or an institutional health
28 facility controlled directly or indirectly by a health
29 maintenance organization or combination of health maintenance
30 organizations, except when the health maintenance organization
31 or combination of health maintenance organizations does any of
32 the following:

33 (1) Constructs, develops, renovates, relocates, or
34 otherwise establishes an institutional health facility.

35 (2) Acquires major medical equipment as provided by section

1 135.61, subsection 16, paragraphs ~~"i"~~ and ~~"j"~~ paragraph "f".

2 Sec. 14. Section 135.62, subsection 2, paragraph h,
3 subparagraph (2), Code 2026, is amended to read as follows:

4 (2) If these conditions are not met, the institutional
5 health facility or health maintenance organization is subject
6 to ~~review as a "new institutional health service" or "changed~~
7 ~~institutional health service" under section 135.61, subsection~~
8 ~~16, paragraph "f", and is subject to sanctions under section~~
9 135.72.

10 Sec. 15. Section 135.62, subsection 2, Code 2026, is amended
11 by adding the following new paragraphs:

12 NEW PARAGRAPH. r. An organized outpatient health
13 facility that provides behavioral health services as defined
14 by the department by rule, including but not limited to
15 substitution-based treatment centers for opiate addiction.

16 NEW PARAGRAPH. s. Open heart surgical services.

17 NEW PARAGRAPH. t. Organ transplantation services.

18 NEW PARAGRAPH. u. Radiation therapy services.

19 NEW PARAGRAPH. v. Cardiac catheterization services.

20 Sec. 16. Section 135.63, subsection 2, paragraph b, Code
21 2026, is amended by striking the paragraph.

22 Sec. 17. Section 135.65, subsections 1 and 2, Code 2026, are
23 amended to read as follows:

24 1. a. Within fifteen business days ~~after receipt of the~~
25 date the department receives an application for a certificate
26 of need, the department shall examine the application for form
27 and completeness and accept or reject it. An application
28 shall be rejected only if it fails to provide all information
29 required by the department pursuant to section 135.62,
30 subsection 1. The department shall ~~promptly return to the~~
31 applicant any a rejected application, to the applicant with an
32 explanation of the reasons for its rejection.

33 b. Within thirty calendar days of the date the department
34 sends a rejected application to an applicant, the applicant may
35 revise and resubmit the application once for review without

1 submitting another application fee under section 135.62.

2 2. Upon acceptance of an application for a certificate
3 of need, the department shall ~~promptly undertake to~~ notify
4 all affected persons ~~in writing~~ through electronic means
5 that formal review of the application has been initiated.
6 Notification to ~~those~~ affected persons who are consumers
7 ~~or third-party payers or other payers for health services~~
8 may be provided by electronic distribution of the pertinent
9 information ~~to the news media.~~

10 Sec. 18. Section 135.65, subsection 3, paragraph b, Code
11 2026, is amended to read as follows:

12 b. A period for the submission of written public hearing
13 comments from affected persons on the application, to be held
14 scheduled prior to completion of the evaluation required by
15 paragraph "a".

16 Sec. 19. Section 135.65, subsection 4, Code 2026, is amended
17 by striking the subsection.

18 Sec. 20. Section 135.66, subsection 1, Code 2026, is amended
19 to read as follows:

20 1. The department may ~~waive the letter of intent procedures~~
21 ~~prescribed by section 135.64~~ and substitute conduct a summary
22 review procedure, ~~which shall be~~ established by rules of
23 adopted by the department, when ~~it~~ the department accepts an
24 application for a certificate of need for a project ~~which that~~
25 meets any of the following criteria ~~in paragraphs "a" through~~
26 ~~"e"~~:

27 a. A project which is limited to repair or replacement of a
28 facility or equipment damaged or destroyed by a disaster, and
29 which will not expand the facility nor increase the services
30 provided beyond the level existing prior to the disaster.

31 b. A project necessary to enable the facility or service to
32 achieve or maintain compliance with federal, state, or other
33 appropriate licensing, certification, or safety requirements.

34 c. A project which will not change the existing bed capacity
35 of the applicant's facility or service, as determined by the

1 department, by more than ten percent or ten beds, whichever is
2 less, over a two-year period.

3 ~~d. A project the total cost of which will not exceed one~~
4 ~~hundred fifty thousand dollars.~~

5 ~~e.~~ d. Any other project for which the applicant proposes
6 and the department agrees to summary review.

7 Sec. 21. Section 135.70, subsection 2, Code 2026, is amended
8 to read as follows:

9 2. Upon expiration of a certificate of need, and prior to
10 extension of the certificate of need, any affected person shall
11 have the right to submit to the department information which
12 may be relevant to the question of granting an extension. ~~The~~
13 ~~department may call a public hearing for this purpose.~~

14 Sec. 22. Section 135.71, subsection 4, Code 2026, is amended
15 to read as follows:

16 4. Criteria for determining when it is not feasible to
17 complete formal review of an application for a certificate of
18 need within the time ~~limits~~ limit specified in [section 135.68](#).
19 The rules adopted under [this subsection](#) shall include criteria
20 for determining whether an application proposes introduction
21 of technologically innovative equipment, and if so, procedures
22 to be followed in reviewing the application. However, a rule
23 adopted under [this subsection](#) shall not permit a deferral of
24 more than ~~sixty~~ thirty calendar days beyond the time when a
25 decision is required under [section 135.68](#), unless both the
26 applicant and the department agree to a longer deferment.

27 Sec. 23. Section 135P.1, subsection 3, Code 2026, is amended
28 to read as follows:

29 3. "*Health facility*" means ~~an~~ any of the following:

30 a. An institutional health facility ~~as defined in section~~
31 ~~135.61, a.~~

32 b. A birth center as defined in [section 135.131, a.](#)

33 c. A hospice licensed under [chapter 135J, a.](#)

34 d. A home health agency as defined in [section 144D.1, an.](#)

35 e. An assisted living program certified under [chapter 231C, r](#)

1 a.

2 f. A clinic,~~a.~~

3 g. A community health center,~~or the.~~

4 h. The university of Iowa hospitals and clinics,~~and~~
5 ~~includes any.~~

6 i. A corporation, professional corporation, partnership,
7 limited liability company, limited liability partnership, or
8 other entity comprised of ~~such~~ health facilities.

9 Sec. 24. Section 135P.1, Code 2026, is amended by adding the
10 following new subsection:

11 NEW SUBSECTION. 3A. "*Institutional health facility*" means
12 any of the following without regard to whether the facility is
13 publicly or privately owned, organized for profit, or is part
14 of or sponsored by a health maintenance organization:

15 a. A hospital as defined in section 135B.1.

16 b. A health care facility as defined in section 135C.1.

17 c. An organized outpatient health facility as defined in
18 section 135.61.

19 d. An ambulatory surgical center as defined in section
20 135.61.

21 e. A community mental health center as defined in section
22 225A.1.

23 Sec. 25. REPEAL. Section 135.64, Code 2026, is repealed.