Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 77
"Conditions of Participation for Providers of Medical and Remedial Care"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapter 249A

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Purpose and Summary

This proposed chapter outlines the qualifications needed for providers to participate in Iowa's Medical Assistance Program.

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result of the Department's review, the Department added or updated dates certain, replaced restrictive terms with less restrictive alternatives, referred language duplicative of federal regulations back to the Code of Federal Regulations, replaced outdated terminology with current terminology, referred items to the appropriate provider manuals, consolidated references to like services, renumbered, and standardized the use of acronyms.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**
- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.
- **Classes of persons that will benefit from the proposed rulemaking:**

Health care providers that want to participate in Iowa's Medical Assistance Program will benefit from this proposed chapter.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**
- **Quantitative description of impact:**

There are 72,358 providers participating in Iowa's Medical Assistance Program.
- **Qualitative description of impact:**

Health care providers that want to participate in Iowa's Medical Assistance Program will benefit from this proposed chapter.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

This proposed chapter has no impact on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required by law.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Rulemaking is required by law.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

No other methods were considered by the Department.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Rulemaking is required by law.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 77 and adopt the following **new** chapter in lieu thereof:

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs will be held confidential.

441—77.3(249A) Pharmacists. An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.

441—77.4(249A) Hospitals.

77.4(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.4(2) *Psychiatric bed tracking system.* As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

a. Definitions.

"Adult beds" means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

"Child beds" means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

"Geriatric beds" means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.

"Hospital," for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

"Psychiatric bed tracking system" means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

b. Hospitals are required to participate in the psychiatric bed tracking system.

c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.

d. Each update must include the number of child beds by sex, the number of adult beds by sex, and the number of geriatric beds by sex.

e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

441—77.5(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state. Note, however, that payment will not be made to a dental laboratory.

441—77.6(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.8(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.9(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate provided that they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) as amended to July 1, 2026, by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act as amended to July 1, 2026.

441—77.10(249A) Home health agencies. Home health agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and, unless otherwise exempted, have submitted a surety bond as required by subrules 77.10(2) through 77.10(4).

77.10(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.10(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the department as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 through 9308 and 31 CFR Part 223, both as amended to July 1, 2026, and 31 CFR Parts 224 and 225, both as amended to July 1, 2026. The bond shall list the surety's name, street address or post office box number; city; state; and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department will give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa will be maintained and will be available for public inspection by contacting the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.10(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.10(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with 42 CFR 484 Subparts A, B, and C as amended to July 1, 2026, and with the Medicare Program Integrity Manual, Chapter 10.2.5.3, as amended to July 1, 2026.

441—77.11(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.12(249A) Ambulance service. Providers of ambulance service are eligible to participate provided that they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026) and Iowa Code section 147A.8.

441—77.13(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24.

441—77.14(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

441—77.15(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

441—77.16(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they are accredited pursuant to 441—Chapter 24.

441—77.17(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in rule 441—78.18(249A) and meet the department's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the department.

441—77.18(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice, and are eligible to participate in the Medicare program.

441—77.19(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

441—77.20(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).

441—77.21(249A) Independent laboratories. Independent laboratories are eligible to participate provided that they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

441—77.22(249A) Rural health clinics. Rural health clinics are eligible to participate provided that they are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026).

441—77.23(249A) Psychologists.

77.23(1) All psychologists licensed to practice in the state of Iowa pursuant to Iowa Code chapter 154B are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the credentialing requirements of the National Register of Health Service Psychologists as amended to July 1, 2026.

77.23(2) A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

77.23(3) A psychologist provisionally licensed in another state is eligible to participate when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

441—77.24(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A) for more information). The prenatal and postpartum care shall be in accordance with the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services, as amended to July 1, 2026.

441—77.25(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if the ambulatory surgical centers are certified to participate in the Medicare program (Title XVIII of the Social Security Act as amended to July 1, 2026). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 481—Chapter 579 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.26(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of the federally qualified health centers' eligibility as allowed by Section 6404(b) of Public Law 101–239 as amended to July 1, 2026.

441—77.27(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to 481—Chapter 621.

77.27(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with 481—Chapter 621.

77.27(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.27(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

441—77.28(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.28(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.28(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

441—77.29(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation.

441—77.30(249A) HCBS habilitation services. To be eligible to participate in the Medicaid program as an approved provider of HCBS habilitation services, a provider shall meet the general requirements in subrules 77.30(2) through 77.30(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.30(1) *Definitions.*

"Certified employment specialist" or *"CES"* means a person who has earned a CES certification through a nationally recognized accrediting body.

"Guardian" means a guardian appointed in probate or juvenile court.

"Home- and community-based services" or *"HCBS"* means the types of person-centered care delivered in the home and community.

"Immediate family member" means any of the following:

(1) Husband or wife.
(2) Natural or adoptive parent, child, or sibling.
(3) Stepparent, stepchild, stepbrother, or stepsister.
(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
(5) Grandparent or grandchild.
(6) Spouse of grandparent or grandchild.

"Individual employment" means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job and for which the member is paid at or above minimum wage but not less than the customary wage and

level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Individual placement and support" or *"IPS"* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org as amended to July 1, 2026.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions.

"IPS 25-item supported employment fidelity scale" means the fidelity scale published by the IPS Employment Center as amended to July 1, 2026, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

"IPS implementation" means the process advocated by the IPS Employment Center as amended to July 1, 2026.

"IPS reviewer" means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of "good" or better; has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS reviewer; and has shadowed one or more IPS fidelity reviews;
2. An existing IPS reviewer from a state that is a member of the IPS International Learning Collaborative;
3. An IPS reviewer contracted directly from the IPS Employment Center;
4. A CES with a bachelor's degree who has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

"IPS team" means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

"IPS trainer" means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa that has obtained a fidelity score of "good" or better and has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS trainer;
2. An existing IPS trainer from a state that is a member of the IPS International Learning Collaborative;
3. An IPS trainer contracted directly from the IPS Employment Center;
4. A CES with a bachelor's degree who has completed the IPS Employment Center's training as amended to July 1, 2026, to become an IPS trainer.

"Managed care organization" or *"MCO"* means the same as defined in 441—Chapter 73.

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

"Mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association as amended to July 1, 2026, 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 DSM published by the American Psychiatric Association as amended to July 1, 2026.

"Prospective IPS team" means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a as amended to July 1, 2026.

"Provider-owned or controlled setting" means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord/tenant laws do not apply, the state will ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

"Provisionally approved IPS team" means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a as amended to July 1, 2026, and (3) begun to deliver IPS services.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder in a child under 18 that significantly impairs the child's ability to function in family, school, or community settings. This impairment must be substantial and have lasted long enough to meet specific diagnostic criteria outlined in the DSM as amended to July 1, 2026.

"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.

77.30(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.30(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS habilitation provider manual as amended to July 1, 2026.

77.30(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.30(5) *Residential and nonresidential settings.* All HCBS, whether residential or nonresidential, shall be provided in accordance with 42 CFR 441.301(4) and (5) as amended to July 1, 2026.

77.30(6) *Case management.* A provider is eligible to participate in the HCBS habilitation program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.30(7) *Day habilitation.*

a. The following providers may provide day habilitation:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by CARF to provide other services and has begun providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7) *"a"*(1), *"a"*(4), or *"a"*(7).

(3) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by the Joint Commission.

b. Direct support staff providing day habilitation services shall meet the qualifications as outlined in the HCBS Manual as amended to July 1, 2026.

77.30(8) *Home-based habilitation.*

a. The following agencies may provide home-based habilitation services:

(1) An agency that is certified by the department to provide supported community living services under:

1. The HCBS intellectual disability waiver pursuant to rule 441—77.40(249A); or

2. The HCBS brain injury waiver pursuant to rule 441—77.42(249A).

(2) An agency that is accredited under 441—Chapter 24 to provide supported community living services.

(3) An agency that is accredited by CARF as a community housing or supported living service provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that is accredited by the Council on Accreditation of Services for Families and Children.

(6) An agency that is accredited by the Joint Commission.

b. Agencies meeting the criteria under subrule 77.30(9) or 77.40(2) that seek certification as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A certified intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) home-based habilitation provider in good standing with Iowa Medicaid.

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

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

(4) Ensure that all staff members have the qualifications outlined in the HCBS Manual as amended to July 1, 2026.

(5) Ensure that within the first year of employment, staff members complete 48 hours of training in the subject matter outlined in the HCBS Manual as amended to July 1, 2026.

(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.

(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services.

(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 with approval from the department.

(13) Be located in a neighborhood setting to maximize community integration and natural supports.

(14) Demonstrate specialization in serving individuals with a serious and persistent mental illness or multi-occurring conditions and serve individuals with similar conditions in the same site.

c. Direct support staff providing home-based habilitation services shall meet the qualifications outlined in the HCBS Habilitation Manual as amended to July 1, 2026.

d. The department will approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

e. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area; and

(2) The county in which the living unit is located provides to the department verification in writing that approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need; or
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.30(9) *Prevocational habilitation.*

a. The following providers may provide prevocational services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall, within six months of hire, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE)-certified training program as amended to July 1, 2026.

(3) Prevocational direct support staff shall complete four hours of continuing education in employment services annually.

77.30(10) *Supported employment habilitation.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by CARF as an organizational employment service provider or a community employment service provider.

(2) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(3) An agency that is accredited by CARF to provide other services and began providing services that qualify as supported employment under 441—subrule 78.27(10) since the agency's last accreditation survey. The agency may provide supported employment services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.30(10)*"a"*(1), *"a"*(2), *"a"*(5), *"a"*(6), *"a"*(7) or *"a"*(8).

(4) An agency that is not accredited by CARF but has applied to CARF within the last 12 months for accreditation to provide services that qualify as supported employment under 441—subrule 78.27(10). An agency that has not received accreditation within 12 months after application to CARF is no longer a qualified provider.

(5) An agency that is accredited by the Council on Accreditation.

(6) An agency that is accredited by the Joint Commission.

(7) An agency that is accredited by the Council on Quality and Leadership.

(8) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council on Quality and Leadership in Supports for People with Disabilities is no longer a qualified provider.

(9) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the qualifications outlined in the HCBS Habilitation Manual and HCBS Waiver Manual, both as amended to July 1, 2026.

d. Providers qualified to offer IPS services shall meet the following requirements:

(1) Providers shall meet the provider qualifications listed in this subrule.

(2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.

(3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.

(4) Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.

(5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.30(1).

(6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a "fair" score on a baseline fidelity review completed by IPS reviewers.

(7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a as amended to July 1, 2026, within 12 months of enrolling.

(8) Upon completion of IPS implementation phase 4a as amended to July 1, 2026, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.

(9) Upon completion of IPS implementation phase 7 as amended to July 1, 2026, IPS teams are qualified to deliver IPS services, subject to the following:

1. IPS teams must obtain a baseline fidelity review score of "fair" or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.

2. In the event an IPS team fails to achieve a fidelity score of "fair" or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than "fair" fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches "fair" fidelity, whichever date is earliest.

3. IPS teams who do not achieve a "fair" fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum "fair" fidelity score.

441—77.31(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.31(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral health professionals as a marital and family therapist pursuant to 481—Chapter 880 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.31(2) *Temporarily licensed marital and family therapists.* Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.

77.31(3) *Licensed independent-level social workers (LISW).* Any person licensed by the board of social work as an independent-level social worker pursuant to 481—Chapter 880 is eligible to participate. An independent-level social worker in another state is eligible to participate when duly licensed to practice in that state.

77.31(4) *Licensed master-level social workers (LMSW).*

a. A person licensed by the board of social work as a master-level social worker pursuant to 481—Chapter 880 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent-level social worker licensed pursuant to 481—Chapter 880.

b. A master-level social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent-level social worker duly licensed in that state.

77.31(5) *Licensed mental health providers (LMP).* Any person licensed by the board of behavioral health professionals as a mental health provider pursuant to Iowa Code chapter 154D and 481—Chapter 880 is eligible to participate. A mental health provider in another state is eligible to participate when duly licensed to practice in that state.

77.31(6) *Temporarily licensed mental health counselors.* Any person temporarily licensed by the board of behavioral health professionals as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral health professionals by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

77.31(7) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of certification as an alcohol and drug counselor is eligible to participate.

77.31(8) *Licensed behavior analysts.* Any person licensed by the board of psychology as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

77.31(9) *Licensed assistant behavior analysts.* A person licensed by the board of psychology as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:

a. Holds current certification as an assistant behavior analyst by a certifying entity; and

b. Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

77.31(10) *Registered behavior technicians.*

a. A person is eligible to participate as a registered behavior technician when the person holds:

(1) A current certification from the behavior science board as a registered behavior technician; or

(2) A bachelor's degree.

b. A registered behavior technician must provide treatment under the supervision of a behavior analyst or assistant behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

441—77.32(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

441—77.33(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.33(1) Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

77.33(2) Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

77.33(3) Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

77.33(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

b. Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

c. Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

d. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

e. Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

77.33(5) Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

77.33(6) Personnel providing vision services shall be:

a. Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

b. Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

c. Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

441—77.34(249A) Case management provider organizations. Case management provider organizations meeting the criteria in 441—Chapter 24 are eligible to participate.

441—77.35(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by an agency meeting the standards and qualifications pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.35(18) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided.

77.35(1) *Home maintenance providers.* Home maintenance providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

77.35(2) *Home health aide providers.* Home health aide providers shall be agencies that are certified to participate in the Medicare program.

77.35(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections, appeals, and licensing (DIAL) as being in compliance with the standards for adult day services programs in 481—Chapter 70.

77.35(4) *Nursing care providers.* Nursing care providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.35(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Hospitals licensed pursuant to 481—Chapter 51.

(3) Nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 through 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home maintenance providers that meet the conditions of participation set forth in subrule 77.35(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.35(3).

(8) Residential care facilities for individuals with intellectual disabilities licensed by DIAL.

(9) Assisted living programs certified by DIAL.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The member's name, birth date, age, and address and the telephone number of each parent, guardian, or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers, such as the number of the member's physician and the parents, guardian, or primary caregiver.

4. The member's medical issues, including allergies.

5. The member's daily schedule that includes the member's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to members and the public. Nonprescription medications shall be labeled with the member's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the member's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.35(6) *Counseling providers.* Counseling providers shall be:

a. Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

b. Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

77.35(7) *Attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. Agencies authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

b. Home health agencies that are certified to participate in the Medicare program.

c. Community action agencies as designated in Iowa Code section 216A.93.

d. Providers certified under an HCBS waiver for supported community living.

e. Assisted living programs that are certified by DIAL under 481—Chapter 69.

f. Adult day service providers that are certified by DIAL under 481—Chapter 70.

g. Community businesses that are engaged in the provision of attendant care services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.35(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.40(2) or 77.42(12).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

77.35(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 441—Chapter 226.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation coverage.

77.35(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the following conditions:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants 24 hours per day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all applicable laws and regulations relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.35(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 441—Chapter 226. Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.35(2).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Homemaker providers meeting the standards set forth in subrule 77.38(4).

77.35(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 481—Chapter 921:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent dietitians licensed pursuant to 481—Chapter 921.

77.35(13) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the following qualifications:

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

c. The financial institution shall enroll as a Medicaid provider.

77.35(14) *Independent support brokerage.* Members who select the consumer choices option may work with an independent support broker who meets the following qualifications:

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.35(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in the HCBS Manual as amended to July 1, 2026.

77.35(18) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

441—77.36(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer, such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.36(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.36(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

441—77.37(249A) Hospice providers. Hospice providers that are licensed and meet the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under the Medicare program for hospice programs are eligible to participate in the Medicaid program.

441—77.38(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver Provider Manual as amended to July 1, 2026. The following providers are eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.38(22) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards set forth below for the service to be provided.

77.38(1) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.38(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants 24 hours per day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority that is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all applicable laws and regulations relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.38(3) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.38(4) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department for local public health services. The agency must provide a current local public health services contract number.

77.38(5) *Nursing care.* Nursing care providers meeting the criteria in subrule 77.35(4) are eligible to participate.

77.38(6) *Respite care.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.38(7) *Home-delivered meals providers.* Home-delivered meals providers meeting the criteria outlined in subrule 77.35(11) are eligible to participate.

77.38(8) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.38(9) *Mental health outreach providers.* Community mental health centers or other accredited behavioral health providers meeting the criteria outlined in rule 441—77.31(249A) may provide mental health outreach services.

77.38(10) *Transportation service providers.* The following providers may provide transportation services:

a. Area agencies on aging as designated in 441—Chapter 226. Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the department of transportation.

d. Supported community living providers certified pursuant to subrule 77.40(2) or 77.42(12).

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation broker.

77.38(11) *Nutritional counseling.* Providers meeting the criteria outlined in subrule 77.35(12) may provide nutritional counseling.

77.38(12) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to 441—Chapter 226.

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.38(13) *Companion services.* Senior companion programs designated by the Corporation for National and Community Service may provide companion services.

77.38(14) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.38(15) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.38(16) *Independent support brokerage.* Members who select the consumer choices option may work with an independent support broker who meets the criteria outlined in subrule 77.35(14).

77.38(17) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.38(18) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.38(19) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.38(20) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the standards outlined in 441—Chapter 90.

77.38(21) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, except for providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

77.38(22) *Assisted living on-call service.* Assisted living on-call service providers shall be assisted living programs that are certified by DIAL under 481—Chapter 69.

441—77.39(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who meets the training and qualification specified in the HCBS Waiver

Provider Manual as amended to July 1, 2026. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program.

77.39(1) *Counseling providers.* Counseling providers that meet the criteria outlined in subrule 77.35(6).

77.39(2) *Home health aide providers.* Home health aide providers that meet the requirements outlined in subrule 77.35(2).

77.39(3) *Home maintenance providers.* Home maintenance providers that meet the requirements outlined in subrule 77.35(1).

77.39(4) *Nursing care providers.* Nursing care providers that meet the requirements outlined in subrule 77.35(4).

77.39(5) *Respite care providers.* Respite care providers that meet the criteria outlined in subrule 77.35(5).

77.39(6) *Home-delivered meal providers.* Home-delivered meal providers that meet the criteria outlined in subrule 77.35(11).

77.39(7) *Adult day care providers.* Adult day care providers that meet the criteria outlined in subrule 77.35(3).

77.39(8) *Attendant care providers.* Attendant care providers that meet the criteria outlined in subrule 77.35(7).

77.39(9) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.39(10) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.39(11) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.39(12) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.39(13) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

77.39(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers, except for providers of goods and services purchased under the consumer choices option or home-delivered meals, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

441—77.40(249A) HCBS intellectual disability waiver service providers. HCBS intellectual disability waiver services shall be rendered by providers meeting the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.40(1) *Review of providers.* Reviews of compliance with standards as indicated in this chapter and the requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, will be conducted by designated department team members.

77.40(2) *Supported community living (SCL) providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of SCL may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. Agencies meeting the criteria under subrule 77.40(2) that seek designation as an intensive residential service provider shall meet the criteria pursuant to paragraph 77.30(8)*"b"* at initial application and annually thereafter.

e. All SCL providers shall meet the following requirements:

(1) The provider shall demonstrate the outcomes and processes in rule 441—77.40(249A) for each of the members being served.

(2) Reserved.

77.40(3) *Respite care providers.* Respite care providers meeting the criteria in subrule 77.35(5) are eligible to participate.

77.40(4) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.25(9) are eligible to participate.

77.40(5) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.40(6) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.40(7) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.40(8) *Home health aide providers.* Home health aide providers meeting the criteria outlined in subrule 77.35(2) are eligible to participate.

77.40(9) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.40(10) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.40(11) *Residential-based supported community living service providers.*

a. The department will only enroll public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for children with an intellectual disability or brain injury under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's intellectual disabilities and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every three years in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.

- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and member representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the member. The service provider shall distribute the policies for member appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
4. Specific service activities to be provided to achieve the objectives.
5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
6. Date of service initiation and date of individual service plan development.
7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child as listed on the Supports Intensity Scale® (SIS) assessment as amended to July 1, 2026.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child as listed on the SIS assessment as amended to July 1, 2026.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(2) The provider supplies the department with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.

2. What physical change will need to take place in the living units.

3. How children and their families will be involved in the transitioning process.

4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.42(7).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.42(8).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, annual recertification will be based on an on-site review and will be contingent upon demonstration of compliance with certification requirements.

The department will hold an exit conference with the provider to share preliminary findings of the recertification review. The department will write and send to the provider a review report within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification will be effective on the date identified on the Certificate of Approval and will terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification

review to give the provider time to establish and implement corrective actions and improvement activities.

• During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

• Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a department review team member encounters a situation that places a member in immediate jeopardy, the department review team member will immediately notify the provider and other department review team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider will not be certified. The department will immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time, the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each department review team member will follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department will establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

• A delay in the department's approval decision exists that is beyond the control of the provider or department.

• A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

• The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to subrule 70.40(1) and numbered paragraph 77.40(11)*"f"*(3)"4."

• The provider has failed to provide information requested pursuant to subrule 70.40(1) and numbered paragraph 77.40(11)*"f"*(3)"4."

• The provider refuses to allow the department to conduct a site visit pursuant to subrule 77.40(1) and subparagraph 77.40(11)*"f"*(3).

• There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services will be subject to reviews of compliance with program requirements.

77.40(12) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.40(13) *Adult day care providers.* Adult day care providers meeting the criteria outlined in subrule 77.35(3) are eligible to participate.

77.40(14) *Prevocational service providers.* Prevocational service providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.40(15) *Day habilitation providers.* Day habilitation services may be provided by agencies meeting the qualifications outlined in subrule 77.30(7).

77.40(16) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.40(17) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.40(18) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.40(19) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.40(20) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

441—77.41(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.41(1) *Minimum composition.* At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.41(2) *Psychiatrists.* A psychiatrist on the team shall be a physician (MD or DO) who:

a. Is licensed under 481—Chapter 653;

b. Is 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; and

c. Has experience treating serious and persistent mental illness.

77.41(3) *Registered nurses.* A nurse on the team shall:

a. Be licensed as a registered nurse under 481—Chapter 617, and

b. Have experience treating persons with serious and persistent mental illness.

77.41(4) *Behavioral health service providers.* A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 481—Chapter 880, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master-level or independent-level social worker under 481—Chapter 880, and

(2) Has experience treating persons with serious and persistent mental illness.

77.41(5) *Psychologists.* A psychologist on the team shall:

a. Be licensed under 481—Chapter 880, and

b. Have experience treating persons with serious and persistent mental illness.

77.41(6) *Substance abuse treatment professionals.* A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)*"b,"* and

b. Have at least three years of experience treating substance abuse.

77.41(7) *Peer specialists.* A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.41(8) *Community support specialists.* A community support specialist on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

77.41(9) *Case managers.* A case manager on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of "qualified case managers and supervisors" in rule 441—24.1(225A).

77.41(10) *Advanced registered nurse practitioners.* An advanced registered nurse practitioner on the team shall:

a. Be licensed under 481—Chapter 621,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.41(11) *Physician assistants.* A physician assistant on the team shall:

a. Be licensed under 481—Chapter 780,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

441—77.42(249A) HCBS brain injury (BI) waiver service providers. HCBS BI waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. Providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct member service must have completed the department's brain injury training modules within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.42(10). Attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrule 77.42(1) and be evaluated according to subrules 77.42(7) through 77.42(9) and meet the requirements of subrules 77.42(2) through 77.42(6). Respite providers shall also meet the standards outlined in subrule 77.42(1).

The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS BI waiver service providers.

77.42(1) *Outcome-based standards.* The provider shall have organizational and rights and dignity outcome-based standards pursuant to the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(2) *The right to appeal.* Members and their legal representatives have the right to appeal the provider's application of policies or procedures or any staff or contractual person's action that affects the member. The provider shall distribute the policies for member appeals and procedures to members.

77.42(3) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers a prescription or an over-the-counter medication, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with rule 481—63.16(135C).

77.42(4) *Research.* If the provider conducts research involving members, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that members' rights are protected.

77.42(5) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS BI waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.42(6) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.42(7) *Certification process.* The department will conduct reviews of compliance with standards for initial certification and recertification. Certification carries no assurance that the approved provider will receive funding.

The department may request any information from the prospective service provider that the department considers pertinent to arriving at a certification decision.

77.42(8) *Initial certification.* The department will review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department will make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The department's decision on the provider's initial certification will be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification will be offered technical assistance.

77.42(9) *Period of certification.* Provider certification will become effective on the date identified on the certificate of approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department will be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification will be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission, CARF, the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with members and significant people in the member's life to determine whether or not the individual value-based outcomes set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026, and corresponding processes are present for the member. Respite services are required to meet certain outcome standards and participate in satisfaction surveys.

(1) Once the outcomes and processes have been determined for all the members in the sample, a department review team then determines which of the outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the members interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the members interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the member, length of certification will be based more heavily on whether or not the processes are in place to help members obtain desired outcomes.

(2) An exit conference will be held with the organization to share preliminary findings of the certification review. The department will write and send a review report to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

(3) Provider certification will become effective on the date identified on the Certificate of Approval and will terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification will be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period will be granted to the provider to establish and implement corrective actions and improvement activities. During this time period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days will not be renewed or extended and will require a full on-site follow-up review to be completed. The provider will be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a department team member encounters a situation that places a member in immediate jeopardy, the department team member will immediately notify the provider and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification will not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney-in-fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time, the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each department team member will be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision that is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department will establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.42(10)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.42(10)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.42(10)*"f."*

(4) There are instances of noncompliance with the standards that were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.42(10) *Departmental reviews.* The department will conduct reviews of compliance with standards as indicated in this chapter. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, members, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews will be conducted annually with additional reviews conducted at the department's discretion.

b. Following a departmental review, the department will submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The provider shall submit the corrective action plan to the department and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.42(10)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.42(11) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS BI waiver program provided the case management provider organizations meet the standards in 441—Chapter 24 and the case management provider organizations are the department, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.42(12) *Supported community living providers.*

a. The department will certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, and 114 through 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. Providers of service may employ or contract individuals meeting the definition of host home to provide supported community living services. These individuals must meet the criteria in the HCBS Waiver Manual as amended to July 1, 2026. A host home is a community-based family home setting whose owner or renter provides HCBS SCL or HCBS home-based habilitation (HBH) services to no more than two unrelated individuals who reside with the owner or renter in their primary residence and who is approved to provide those services as an independent contractor of a community-based SCL or HBH service agency.

e. The department will approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department will approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the department in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.42(13) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

77.42(14) *Supported employment providers.* Supported employment providers meeting the criteria outlined in subrule 77.30(10) are eligible to participate.

77.42(15) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.42(16) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.42(17) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.42(18) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program that provide specialized medical equipment as described in 441—subrule 78.43(8).

77.42(19) *Adult day care providers.* Adult day care providers shall be agencies that meet the criteria outlined in subrule 77.35(3).

77.42(20) *Family training providers.* Family training providers shall be one of the following:

a. Providers certified under the community mental health center standards set forth in 441—Chapter 24 and that employ staff to provide family training who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs and that employ staff who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards set forth in 441—Chapter 24 and that employ staff to provide family training who meet the definition of "qualified brain injury professional" as set forth in rule 441—83.81(249A).

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

e. Agencies certified as HCBS BI waiver service providers pursuant to rule 441—77.42(249A) that employ staff to provide family training who meet the definition of a "qualified brain injury professional" as set forth in rule 441—83.81(249A).

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

77.42(21) *Prevocational habilitation.* Prevocational habilitation services providers meeting the criteria outlined in subrule 77.30(9) are eligible to participate.

77.42(22) *Positive behavioral support and consultation providers.* Positive behavioral support and consultation providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements:

a. Behavior assessment and development of an appropriate intervention plan with periodic reassessment of the appropriate intervention plan, and training of staff who shall implement the appropriate intervention plan must be done by a "qualified brain injury professional" as defined in rule 441—83.81(249A). Formal assessment of the members' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a "qualified brain injury professional" as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies that are certified under the community mental health center standards set forth in 441—Chapter 24.

(2) Agencies that are licensed as meeting the hospice standards and requirements set forth in 481—Chapter 53 or that are certified to meet the standards under Medicare for hospice programs.

(3) Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24.

(4) Home health aide providers meeting the standards outlined in subrule 77.35(2). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) HCBS BI waiver service providers certified pursuant to rule 441—77.42(249A).

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

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

77.42(23) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.42(24) *Interim medical monitoring and treatment providers.* Interim medical monitoring and treatment providers meeting the criteria outlined in subrule 77.35(8) are eligible to participate.

77.42(25) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications outlined in subrule 77.35(13).

77.42(26) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications outlined in subrule 77.35(14).

77.42(27) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements outlined in subrule 77.35(15).

77.42(28) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements outlined in subrule 77.35(16).

77.42(29) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements outlined in subrule 77.35(17).

441—77.43(249A) HCBS physical disability waiver service providers. HCBS physical disability waiver service providers shall meet the standards and qualifications outlined in the HCBS Waiver Provider Manual as amended to July 1, 2026. The integrated, community-based settings standards in subrule 77.30(5) apply to all HCBS physical disability waiver service providers.

77.43(1) *Enrollment process.* The department will conduct reviews of compliance with standards for initial enrollment. Enrollment carries no assurance that the approved provider will receive funding and may occur at any time. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.43(2) *Attendant care providers.* Attendant care providers meeting the criteria outlined in subrule 77.35(7) are eligible to participate.

77.43(3) *Home and vehicle modification providers.* Home and vehicle modification providers meeting the criteria outlined in subrule 77.35(9) are eligible to participate.

77.43(4) *Personal emergency response system providers.* Personal emergency response system providers meeting the criteria outlined in subrule 77.35(10) are eligible to participate.

77.43(5) *Specialized medical equipment providers.* Specialized medical equipment providers meeting the criteria outlined in subrule 77.42(18) are eligible to participate.

77.43(6) *Transportation service providers.* Transportation service providers meeting the criteria outlined in subrule 77.38(10) are eligible to participate.

77.43(7) *Financial management service.* Members who select the consumer choices option may work with a financial institution that meets the qualifications in subrule 77.35(13).

77.43(8) *Independent support brokerage.* Members who select the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.35(14).

77.43(9) *Self-directed personal care.* Members who select the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.35(15).

77.43(10) *Individual-directed goods and services.* Members who select the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.35(16).

77.43(11) *Self-directed community supports and employment.* Members who select the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in subrule 77.35(17).

77.43(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers, except for providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

441—77.44(249A) Public health agencies. A public health agency is eligible to participate in the medical assistance program when the public health agency serves as a public health entity within a local board of health jurisdiction pursuant to rule 641—77.3(137).

441—77.45(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA) as amended to July 1, 2026; and
2. Meets the following additional requirements.

77.45(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Licensed by the board of educational examiners as a mental health professional pursuant to rule 282—16.9(256);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621.

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapter 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.31(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to rule 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.45(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP), including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.24(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the IFSP.

441—77.46(249A) Local education agency (LEA) services providers. School districts accredited by the department of education pursuant to 281—Chapter 12 and Iowa educational services for the blind and the Iowa school for the deaf, both of which are governed by the department of education pursuant to Iowa Code section 256.95, are eligible to participate in the medical assistance program as providers of LEA services under rule 441—78.50(249A) if the following conditions are met.

77.46(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 481—Chapter 740.

b. Personnel providing physical therapy shall be licensed by the board of physical and occupational therapy as a physical therapist pursuant to 481—Chapter 800.

c. Personnel providing occupational therapy shall be licensed by the board of physical and occupational therapy as an occupational therapist pursuant to 481—Chapter 804.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(2) Licensed by the board of psychology as a psychologist pursuant to 481—Chapter 880;

(3) Licensed by the board of social work as a social worker pursuant to 481—Chapter 880;

(4) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 481—Chapter 621(124,147,152).

e. Personnel providing nursing services shall be licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620.

f. Personnel providing vision services shall be:

(1) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620;

(2) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654; or

(3) Licensed by the board of optometry as an optometrist pursuant to 481—Chapter 760.

g. Developmental services shall be provided by personnel who meet standards established pursuant to rule 281—120.13(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to rule 281—41.403(256B);

(2) Endorsed by the board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(2);

(3) Endorsed by the board of educational examiners as a speech-language pathologist pursuant to 282—subrule 27.3(3);

(4) Endorsed by the board of educational examiners as an orientation and mobility specialist pursuant to rule 282—22.12(256);

(5) Endorsed by the board of educational examiners as a school occupational therapist pursuant to rule 282—16.5(256);

(6) Endorsed by the board of educational examiners as a school physical therapist pursuant to rule 282—16.6(256);

(7) Endorsed by the board of educational examiners as a school nurse pursuant to rule 282—16.4(256);

(8) Endorsed by the board of educational examiners as a school social worker pursuant to rule 282—16.7(256);

(9) Licensed by the nursing board as a registered or licensed practical nurse pursuant to 481—Chapters 617 through 620; or

(10) Licensed by the board of medicine as a physician pursuant to 481—Chapters 652 through 654.

77.46(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII.

441—77.47(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638 as amended to July 1, 2026) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 U.S.C. 1603 as amended to July 1, 2026, is eligible to participate in the medical assistance program if the following conditions are met.

77.47(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.47(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

441—77.48(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.48(1) and the integrated, community-based settings standards in subrule 77.30(5) and also meet the standards in subrules 77.48(2) through 77.48(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.48(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards.

a. *Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. *Direct care staff.*

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the member or the parent or stepparent of the member.

c. *Outcome-based standards and quality assurance.*

(1) Providers shall implement the outcome-based standards for the rights and dignity of children with serious emotional disturbance as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

(2) The department will conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review will include interviews with the member and the member's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action will be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action will be available from the department's quality assurance staff.

d. *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers, except for providers of environmental modifications and adaptive devices, must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with incident management and reporting requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

77.48(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS intellectual disability or BI waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.48(3) *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under rule 441—77.13(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* As a condition of providing family and community support services under the children's mental health waiver, the agency shall meet the staff training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

c. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized "crisis intervention plan" as defined in rule 441—24.1(225A) that is developed by each member's interdisciplinary team as set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

d. *Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.48(4) *In-home family therapy providers.*

a. *Qualified providers.* The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 481—Chapter 880 or possessing an equivalent license in another state.

b. *Staff training.* As a condition of providing in-home family therapy under the children's mental health waiver, the agency shall meet the training requirements set forth in the HCBS Waiver Provider Manual as amended to July 1, 2026.

c. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized "crisis intervention plan" as defined in rule 441—24.1(225A) that is developed by each member's interdisciplinary team.

d. *Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.48(5) *Respite care providers.* Respite care providers meeting the criteria outlined in subrule 77.35(5) are eligible to participate.

441—77.49(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

441—77.50(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

441—77.51(249A) Community-based neurobehavioral rehabilitation services.

77.51(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

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

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

77.51(2) *Eligible providers.* The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.51(3) *Provider standards.* All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

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

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

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

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

1. Have a bachelor's degree in a human services-related field;
2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;
3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or
4. Be a CBIS certified through the ACBIS or have other nationally recognized brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum, the training includes the following:

(1) Completion of the department-approved brain injury training modules.
(2) Member rights.
(3) Confidentiality and privacy.
(4) Dependent adult and child abuse prevention and mandatory reporter training.
(5) Individualized rehabilitation treatment plans.
(6) Major mental health disorder basics.

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

d. Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.51(3)*"a"*(6).

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

f. The organization shall have in place an outcome management system that measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.
(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.
(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.30(3) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

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

441—77.52(249A) Qualified Medicare beneficiary (QMB) providers. Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider. A QMB-eligible member must meet the criteria outlined in 441—subrule 75.1(29).

77.52(1) *Reimbursement.* A QMB provider may only bill the department for the QMB-eligible member's Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

77.52(2) *Definitions.*

"Coinsurance" means a percentage of costs of a covered health care service that has to be paid.

"Copayment" means a fixed amount a member pays for a covered health care service.

"Deductible" means the amount paid for covered health care services before the insurance plan will effect payment.

"Medicare cost sharing" means the Medicare member's responsibility for a Medicare-covered service. "Medicare cost sharing" includes coinsurance, copayments, and deductibles.

"Qualified Medicare beneficiary" or *"QMB"* means an individual who has been determined eligible for the QMB program pursuant to 441—paragraph 75.6(5)*"a."* Under the QMB program, Medicaid pays the individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

441—77.53(249A) Health insurance premium payment (HIPP) providers. Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket, cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance paid for through the HIPP program. HIPP-eligible members must meet the criteria outlined in rule 441—75.21(249A).

441—77.54(249A) Crisis response services.

77.54(1) *Definitions.* The terms used in this rule shall have the same meaning as those set out in 441—Chapter 24.

77.54(2) *Eligible providers.* Agencies that are accredited under the mental health service provider standards set forth in 441—Chapter 24 are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

77.54(3) *Provider standards.* All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24.

441—77.55(249A) Subacute mental health services.

77.55(1) *Definitions.* The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

77.55(2) *Subacute mental health services.* Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

77.55(3) *Eligible provider.* Subacute mental health care facilities that are licensed by DIAL in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

77.55(4) *Provider standards.* All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

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