

CHAPTER 90
TARGETED CASE MANAGEMENT

PREAMBLE

These rules define and structure medical assistance targeted case management services provided in accordance with Iowa Code section 225C.20 for Medicaid members with an intellectual disability, a chronic mental illness, or a developmental disability and members eligible for the home- and community-based services (HCBS) children's mental health waiver. Provider accreditation standards are set forth in 441—Chapter 24.

Case management is a method to manage multiple resources effectively for the benefit of Medicaid members. The service is designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—90.1(249A) Definitions.

“*Adult*” means a person 18 years of age or older on the first day of the month in which service begins.

“*Child*” means a person under 18 years of age.

“*Chronic mental illness*” means the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.

2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.

3. They show severe inability to establish or maintain a personal social support system.

4. They require help in basic living skills.

5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

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

“*Developmental disability*” means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. Is manifested before the age of 22;

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which:

1. Is made only when the onset of the person's condition was during the developmental period;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"Major incident" means an occurrence involving a member using the service that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; or
2. Results in a member's death or the death of another person; or
3. Requires emergency mental health treatment for the member; or
4. Requires the intervention of law enforcement; or
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3."
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in 42 Code of Federal Regulations 435.1009, as amended to October 1, 2001. A residential care facility is not a medical institution.

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

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a person may share a residence.

"Targeted case management" means services furnished to assist members who are part of a targeted population and who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other services in order to ensure the health, safety, and welfare of the members. Case management is provided to a member on a one-to-one basis by one case manager.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness or developmental disability; or
2. A child who is eligible to receive HCBS intellectual disability waiver or HCBS children's mental health waiver services according to 441—Chapter 83.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—90.2(249A) Eligibility. A person who meets all of the following criteria shall be eligible for targeted case management:

- 90.2(1)** The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35).
- 90.2(2)** The person is a member of the targeted population.
- 90.2(3)** The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.5(3).
- 90.2(4)** The person has applied for targeted case management in accordance with the policies of the provider.

90.2(5) The person's need for targeted case management has been determined in accordance with rule 441—90.3(249A).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

441—90.3(249A) Determination of need for service.

90.3(1) *Authorization required.* Rescinded IAB 7/15/09, effective 7/1/09.

90.3(2) *Need for service.* Assessment of the need for targeted case management is required at least annually as a condition of payment under the medical assistance program. The case management provider shall determine the initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

a. The member has a need for targeted case management to manage needed medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member.

b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

c. The member is not receiving other paid benefits under the medical assistance program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

90.3(3) *Managed health care.* Rescinded IAB 1/6/16, effective 1/1/16.

90.3(4) *Transition authorization.* Rescinded IAB 7/15/09, effective 7/1/09.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—90.4(249A) Application. The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit if other services are needed or requested.

90.4(1) *Application process and documentation.* The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. The provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

90.4(2) *Application decision.* The provider shall inform the applicant or the applicant's legally authorized representative of any decision to approve, deny, or delay the service in accordance with notification requirements at 441—subrule 7.7(1).

90.4(3) *Delayed services.* The application shall be approved and the member put on the referral list for assignment to a case manager when targeted case management cannot begin immediately because there is no opening on a caseload. The provider shall notify the applicant or the applicant's legally authorized representative in writing of approval and placement on the referral list. If an applicant is on a referral list for more than 90 days from the date of application, this shall be considered a denial of service.

90.4(4) *Denying applications.* The provider shall deny applications for service when:

a. The applicant is not currently eligible for Medicaid; or

b. The applicant does not meet the eligibility criteria in rule 441—90.2(249A); or

c. The applicant or the applicant's legally authorized representative withdraws the application; or

d. The applicant does not provide information required to process the application; or

e. The applicant is receiving targeted case management from another Medicaid provider; or

f. The applicant does not have a need for targeted case management.

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

441—90.5(249A) Service provision.

90.5(1) *Covered services.* The following shall be included in the assistance that case managers provide to members in obtaining services:

a. *Assessment.* The case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using Form 470-4694, Targeted Case Management

Comprehensive Assessment, to determine the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

(1) Taking the member's history, including current and past information and social history in accordance with 441—subrule 24.4(2), and updating the history annually.

(2) Identifying the needs of the member and completing related documentation.

(3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.

b. Service plan. The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals. This plan shall:

(1) Document the parties participating in the development of the plan.

(2) Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.

(3) Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.

(4) Document services identified to meet the needs of the member which the member declined to receive.

(5) Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:

1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.

2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change. The interdisciplinary team shall determine which of the following options will be included in the crisis intervention plan:

- After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or

- After-hours contact information for an on-call system for the provider of case management to ensure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.

(6) Include a discharge plan.

(7) Be revised at least annually, and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and related activities. The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and follow-up. The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.

(2) The member has declined services in the service plan.

(3) Communication is occurring among all providers to ensure coordination of services.

(4) Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.

(5) There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts. Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

(1) The case manager shall have at least one face-to-face contact with the member every three months.

(2) The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals. This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, E-mail, and fax, when the written communication directly pertains to the needs of the member. E-mail contacts are allowed only when other means of communication are not feasible for the member, representative or family and the necessity for E-mail communication is documented in the member's comprehensive service plan. A copy of any written communication must be maintained in the case file. When E-mail communication is used, there must be clear two-way communication in the member's record showing an exchange of information as well as follow-up activity related to the information.

(3) The case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member access services, identifying needs and supports to assist the member in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the member's needs.

(4) When applicable, documentation of case management contacts shall include:

1. The name of the service provider.

2. The need for and occurrences of coordination with other case managers within the same agency or of referral or transition to another case management agency.

90.5(2) Exclusions. Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service, including but not limited to assertive community treatment (ACT).

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs.

(2) Public guardianship programs.

(3) Special education programs.

(4) Child welfare and child protective services.

(5) Foster care programs.

c. The activities are integral to the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program.

(2) Assessing adoption placements.

(3) Recruiting or interviewing potential foster care parents.

(4) Serving legal papers.

(5) Home investigations.

(6) Providing transportation.

(7) Administering foster care subsidies.

(8) Making placement arrangements.

d. The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

90.5(3) *Transition to a community setting.* Case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management under a targeted population. Transitional case management is not an allowable service under the HCBS brain injury waiver, the HCBS elderly waiver, or HCBS habilitation services.

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning.

c. The amount, duration, and scope of case management services shall be documented in the member's plan of care, which must include case management services before and after discharge, to facilitate a successful transition to community living.

d. Payment shall be made only for services provided by community case management providers.

e. Claims for reimbursement for case management shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

90.5(4) *Rights restrictions.* Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes:

a. Documentation of why there is a need for the restriction;

b. A plan to restore those rights or a reason why restoration is not necessary or appropriate; and

c. Documentation that periodic evaluations of the restriction are conducted to determine continued need.

90.5(5) *Documentation.* Service documentation shall also meet the requirements set forth in rule 441—79.3(249A) and 441—subrule 24.4(4).

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9588B, IAB 6/29/11, effective 9/1/11]

441—90.6(249A) Terminating services.

90.6(1) Targeted case management shall be terminated when:

a. The member does not meet eligibility criteria under rule 441—90.2(249A); or

b. The member has achieved all goals and objectives of the service; or

c. The member has no current need for targeted case management; or

d. The member receiving targeted case management based on eligibility under an HCBS waiver is no longer eligible for the waiver; or

e. The member or the member's legally authorized representative requests termination; or

f. The member is unwilling or unable to accept further services; or

g. The member or the member's legally authorized representative fails to provide access to information necessary for the development of the service plan or implementation of targeted case management.

90.6(2) The provider shall notify the member or the member's legally authorized representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

441—90.7(249A) Appeal rights.

90.7(1) *Appeal to the provider.* After notice of an adverse decision by the provider of targeted case management, the member or the member's representative may request an appeal as provided in the appeal process established by the provider agency.

90.7(2) *Appeal to the department.* After notice of an adverse decision by the department pertaining to authorization and need for service, the member or the member's representative may request reconsideration by the department by sending a letter to the department not more than 30 days after

the date of the notice of adverse decision. The member or the member's representative may appeal an adverse reconsideration decision by the department as provided in 441—Chapter 7.

90.7(3) *Appeal to the managed health care contractor.* After notice of an adverse decision by a managed health care plan, the member or the member's representative may request a review as provided in rule 441—88.68(249A).

[ARC 7957B, IAB 7/15/09, effective 7/1/09]

441—90.8(249A) Provider requirements.

90.8(1) *Incident reporting.*

a. When a major incident occurs during the provision of case management services:

(1) The case management provider shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The case management supervisor.
2. The member's legally authorized representative.

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all case management staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the case manager took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) The case manager shall monitor the situation as required in paragraph 90.5(1) "d" to ensure the member's needs continue to be met. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager.

(5) The case management provider shall maintain the completed report in a centralized file, with a notation in the member's file.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation as required in paragraph 90.5(1) "d" to ensure the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the comprehensive assessment as required in paragraph 90.5(1) "a" in order to ensure the continued health, safety, and welfare of the member.

90.8(2) *Emergency coverage.* Rescinded IAB 6/29/11, effective 9/1/11.

90.8(3) *Quality assurance.* Providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

- a.* Postpayment reviews of case management services,
- b.* Review of incident reports,
- c.* Review of reports of abuse or neglect, and

d. Technical assistance in determining the need for service.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 2361C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.

[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]¹

[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]

[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]

[Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]

[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]

[Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]

[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

¹ January 1, 2003, effective date of 90.2(5) and 90.3 delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.