CHAPTER 90
FEE-FOR-SERVICE CASE MANAGEMENT

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

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.

"Applicant" means a person who has applied for an HCBS waiver or habilitation program.

"Case management" means the categories of case management: targeted case management (TCM) and case management provided to members enrolled in a 1915(c) waiver.

"Case manager" means the staff person providing the case management services regardless of the entity providing the service.

"Child" means a person other than an adult.

"Chronic mental illness" means a 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. The definition of chronic mental illness and qualifying criteria are found in 441—Chapter 24. For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Core standardized assessment" or *"CSA"* means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant's or member's needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs.

"Developmental disability" means a severe, chronic disability that is determined through professionally administered screening and evaluations.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act as amended to July 1, 2026.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in 441—Chapter 83.

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that:

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

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

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 CFR Section 435.1009 as amended to October 20, 2022.

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

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, TCM, or habilitation services and that is not a major incident but that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"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 member may share a residence.

"Targeted case management" or *"TCM"* means case management services furnished to assist members who are part of a targeted population.

"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 waiver services according to 441—Chapter 83.

A member enrolled with an MCO is not part of the targeted population.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.2(249A) Targeted case management. This rule applies only to the case management category of TCM and the defined targeted population.

90.2(1) *Eligibility for targeted case management.* A person who meets all of the following criteria will be eligible for TCM:

a. The person is eligible for Medicaid or is conditionally eligible under 441—Chapter 75;

b. The person is a member of a targeted population;

c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);

d. The person has applied for TCM in accordance with the policies of the provider;

e. The person is not eligible for or enrolled in an MCO.

90.2(2) *Determination of need for targeted case management.* Assessment at least every 365 days since the date of identified need for TCM is required as a condition of eligibility under the medical assistance program. The TCM provider manual found on the department's website and as amended to July 1, 2026, contains more information.

90.2(3) *Application for targeted case management.* The TCM provider shall process a received application for TCM no later than 30 days after receipt of the application. The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, has more information.

a. Application decision for targeted case management. The TCM provider shall inform the applicant, or the applicant's guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements in 441—Chapter 16.

b. Denial of applications. The TCM provider will deny an application for service when:

(1) The applicant is not currently eligible for Medicaid;
(2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);
(3) The applicant, or the applicant's guardian or representative, withdraws the application;
(4) The applicant does not provide information required to process the application;
(5) The applicant is receiving duplicative TCM from another Medicaid provider; or
(6) The applicant does not have a need for TCM.

90.2(4) *Transition to a community setting.* The Medicaid manual for TCM found on the department's website and as amended to July 1, 2026, contains information about services that may be provided to a member transitioning to a community setting.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.3(249A) Termination of TCM services.

90.3(1) TCM shall be terminated only when:

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

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

c. The member has no ongoing need for TCM;

d. The member is receiving TCM based on eligibility under an HCBS program but is no longer eligible for the program;

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

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

g. The member or the member's guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of TCM.

90.3(2) The provider shall notify the member or the member's guardian or representative in writing of the termination of TCM, in accordance with 441—Chapter 16.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.4(249A) Case management services. This rule applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in FFS case management services provided to members.

a. Assessment. Initial assessments and regular reassessments must be completed for each member to determine the need for medical, social, educational, housing, transportation, vocational, or other services, as specified in the Medicaid manual for TCM found on the department's website and as amended through July 1, 2026.

b. Person-centered service plan. The case manager shall develop and revise a comprehensive, person-centered service plan at least every 365 days in accordance with the Medicaid manual for TCM found on the department's website and as amended to July 1, 2026.

c. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member.

d. Contacts. The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly. The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face-to-face or by telephone.

90.4(2) *Exclusions.* Payment will not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

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.

c. The activities are components of the administration of foster care programs.

d. The activities for which a member may be eligible are a component of 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 as amended to August 1, 2025.

e. The activities duplicate institutional discharge planning.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.5(249A) Rights restrictions. This rule applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member, or the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. For more information, refer to the Person Centered Service Plan manual as amended to July 1, 2026, available on the department's website.

[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.6(249A) Documentation and billing. This rule applies to all categories of case management and all populations covered by case management. The case management billing manual for case management contact documentation and billing requirements available on the department's website and as amended to July 1, 2026, contains more information.
[**ARC 0319D**, IAB 5/27/26, effective 7/1/26]

441—90.7(249A) Case management services provider requirements.

90.7(1) This rule applies to all categories of case management and all populations covered by case management. Major or minor incidents shall be reported according to the case management incident reporting manual available on the department's website and as amended to July 1, 2026.

90.7(2) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by Iowa Medicaid, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include but are not limited to:

a. Postpayment review 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 0319D**, IAB 5/27/26, effective 7/1/26]

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

[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]
[Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]
[Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]
[Filed ARC 6854C (Notice ARC 6643C, IAB 11/16/22), IAB 2/8/23, effective 4/1/23]
[Filed ARC 0319D (Notice ARC 9854C, IAB 12/24/25), IAB 5/27/26, effective 7/1/26]

[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.