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

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

*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 targeted case management in accordance with the policies of the provider;

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

*f.* The person is not eligible for, or enrolled in, Medicaid managed care.

**90.2(2)** *Determination of need for targeted case management.* Assessment at least every 365 days of the need for targeted case management is required as a condition of eligibility under the medical assistance program. The targeted case management provider shall determine the member's 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 necessary 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; and

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

**90.2(3)** *Application for targeted case management.* 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 or mental health and disability services regions if other services outside the scope of case management are needed or requested.

*a. 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. For FFS members, 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 services agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

*b. Application decision for targeted case management.* The case manager 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 at 441—Chapter 16.

*c. Denial of applications.* The case manager shall 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 targeted case management or integrated health home care coordination from another Medicaid provider; or

(6) The applicant does not have a need for targeted case management.

**90.2(4)** *Transition to a community setting.* Managed care organizations must provide transition services to all enrolled members. Fee-for-service targeted 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 and is a member of a targeted population. Transitional case management is not an allowable service for other HCBS programs or populations;

*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 service plan, 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 Medicaid-enrolled targeted case management providers; and

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

[**ARC 4897C**, IAB 2/12/20, effective 3/18/20; **ARC 4973C**, IAB 3/11/20, effective 4/15/20; **ARC 6854C**, IAB 2/8/23, effective 4/1/23]