

441—83.21(249A) Definitions.

“*Basic individual respite*” means respite provided on a staff-to-member ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Case management*” means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, and community-based case management provided through managed care.

“*Case manager*” means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“*Managed care*” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“*Managed care organization*” or “*MCO*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility that has been approved as a Medicaid vendor.

“*Member*” means an individual who has been determined eligible and has been enrolled to receive Medicaid pursuant to rule 441—75.3(249A) or 441—75.6(249A), excluding medically needy, and is a recipient of waiver services.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a person-centered, outcome-based plan of services that is written by the member’s case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 as amended to July 1, 2026.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.10(249A).
3. Documentation submitted for review indicates that the member has:
 - A physician order for all skilled services.
 - Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - An individualized care plan that identifies support needs.
 - Confirmation that skilled services are provided to the member.
 - Skilled services that are provided by, or under the supervision of, medical personnel as described above.

- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Third-party payment” means payment from an individual, institution, corporation, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

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