

IOWA DEPARTMENT OF PUBLIC HEALTH

Iowa's Title V Maternal and Child Health Services



ADMINISTRATIVE MANUAL

4th Edition

Iowa Department of Public Health

Maternal and Child Health

Administrative Manual

Fourth Edition

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Iowa Department of Public Health
**Maternal and Child Health
Administrative Manual**

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Overview and Structure

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101 Purpose of the MCH Manual

Authority: not applicable
Effective Date: January 19, 2012
Initial Revision
Replaces: 103 – October 2008

Purpose of the manual

The MCH Administrative Manual provides the basis for the development of business practices and programming for maternal and child health services made available through an Iowa Department of Public Health (IDPH) competitive bid process every five years.

For each five year project period, policies in the manual provide the basis for the competitive Request for Proposal (RFP). During intervening years, policies provide the basis for the RFP and the Request for Application (RFA) covering the applicable contract year.

Use of the manual

The MCH Administrative Manual is used by IDPH staff and MCH contract agency staff. A glossary containing definitions of terms used in the manual can be found in appendix A3. Whenever possible, hyperlinks to primary references have been included in the electronic version of this manual. Please note that website addresses are subject to change without notice.

Grant management and program administration policies apply to all MCH-related programs. Supporting materials related to individual programs are included in the following manuals and handbooks:

- EPSDT Informing and Care Coordination Handbook
- I-Smile™ Oral Health Coordinator Handbook
- Family Planning Manual
- CARES User Manual
- WHIS User Handbook

Integration with family planning programs

Because family planning services are included in the MCH-FP contract issued by IDPH, family planning programs are governed by business operations policies in this manual. Specific family planning policies and procedures can be found in the IDPH Family Planning Manual.

Revisions

The MCH Administrative Manual delineates the MCH core services and reflects changes in program funding. The manual is a dynamic document that may be continuously edited and updated. Each year a thorough evaluation is completed to assess whether manual revisions are necessary. Every effort is made to distribute manual revisions at the beginning of the contract period in October of each year.

Distribution of manual revisions is provided in two forms.

- The entire revised manual is placed on the IDPH website.
- Hard copies of revised policies and/or revised appendices are distributed to all MCH and FP contract agencies.

When any change is made to a policy, the revised policy is printed in its entirety and distributed to hard copy manual users. Following distribution of hard copy revisions, it is the responsibility of the manual user to insert the revised policy into the user's hard copy manual.

The MCH Administrative Manual project manager in the IDPH Bureau of Family Health is responsible for coordinating the revision process. It is the responsibility of the manual user to submit requests for changes, revisions and additions to the project manager by April 15 for inclusion in revisions to be published the following October.

The annual review and/or revision process does not preclude revisions that might be needed at other times of the year. Manual users, both state and local, may request consideration of manual revisions at any time. All such requests are routed through the MCH Administrative Manual project manager in the Bureau of Family Health.



102 Mission and Vision Statements

Authority: Iowa department of public health executive team

Effective Date: January 19, 2012

Initial Revision

Replaces: 101 – October 2008

Iowa Department of Public Health

**Mission
statement**
**Vision
statement**

Promoting and protecting the health of Iowans

Healthy Iowans living in a healthy environment

Bureau of Family Health

**Mission
statement**
**Vision
statement**

Promoting the health and well-being of families

Healthy families in healthy communities

Bureau of Oral and Health Delivery Systems Oral Health Center

**Mission
statement**

Protecting the health and wellness of every Iowan through the prevention and early detection of dental disease and through the promotion of optimal oral health

**Vision
statement**

Every Iowan is free from the silent epidemic of dental disease and is empowered to maintain optimal oral health



103 Federal and State Legislative Authority

AUTHORITY: PL 101-239 (OBRA); IOWA ADMINISTRATIVE CODE 641-76; IOWA ADMINISTRATIVE CODE 641 IAC 74; PUBLIC LAW 105-17: IDEA '97: PART C; HRSA 42 USC SECTION 705(A)(5)(F); (IOWA ADMINISTRATIVE CODE 281 IAC 120.4-120.8)

Effective Date: January 19, 2012

Initial Revision

Replaces: 102—October 2008

History

Federal authority for the Maternal and Child Health program in Iowa is derived from Title V of the Social Security Act. In 1935, Congress enacted Title V of the Social Security Act which authorized the Maternal and Child Health Services Program and provided a foundation and structure for assuring the health of mothers and children. Today, Title V is administered by the Maternal and Child Health Bureau as part of the Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

In 1935, Title V created the first federal-state partnerships in Maternal and Child Health services (MCH), Crippled Children's services and Child Welfare services. Over the years, the Title V MCH program was amended several times in order to respond to socioeconomic realities and changes in political ideology. A major change to Title V MCH was the creation of the Maternal and Child Health Services Block Grant as part of the Omnibus Budget Reconciliation Act of 1981 (OBRA 81).

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) significantly changed the MCH Services Block Grant again. States are now required to focus their efforts on preventive and primary health care for children, pregnant women and infants, and children with special health care needs. OBRA 89 requires states to improve accountability by conducting and submitting a periodic statewide needs assessment and report on the status of women and children served by the block grant.

Block grants

The Title V MCH Services Block Grant program currently has three components: formula block grants to 59 states and territories, Special

Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS) grants. The Title V Maternal and Child Health Services Block Grant can be found in appendix A1 of this manual.

The purpose of the block grants to the states is to create federal/state partnerships to develop service systems in our nation's communities to meet critical challenges in maternal and child health, including:

- Significantly reducing infant mortality;
- Providing comprehensive care for women before, during and after pregnancy and childbirth;
- Providing preventive and primary care services for children and adolescents;
- Providing comprehensive care for children and adolescents with special health needs;
- Immunizing all children;
- Reducing adolescent pregnancy rates;
- Preventing injury and violence;
- Putting into community practice national standards and guidelines for prenatal care, healthy and safe child care, and the health supervision of infants, children and adolescents;
- Assuring access to care for all mothers and children; and
- Meeting the nutritional and developmental needs of mothers, children and families.

**Iowa
Administrative
Code**

The Iowa Administrative Code (IAC), Chapter 641 IAC 76, can be found in appendix A2 of this manual. IAC Chapter 76 provides the authority for Iowa's Maternal and Child Health Program. The code adopts the Omnibus Reconciliation Act of 1989 (OBRA 89, PL 101-239) requirements. Responsibility for operation of the Maternal and Child Health Block Grant (Title V MCH) is given by the code to the Iowa Department of Public Health, Bureau of Family Health.

**Accountable
Government
Act**

On June 1, 2001 the Accountable Government Act (AGA) was signed into Iowa law. The AGA aligns the legislative and executive branches around a common focus on, and framework for, results. The AGA requires state government agencies to adopt strategic planning, agency performance planning, performance measurement, results-based budgeting, performance reporting, performance audits and return on investment.

Outcome measures for core functions in each agency help decision makers and Iowans assess and track the agency's overall

performance. Performance measures for services, products and activities include measures of inputs, outputs, quality, efficiency and outcomes. The resulting performance data informs decisions and communications. Performance data tell lowans, including stakeholders and employees, what state government is accomplishing.

Integration of Title V and Medicaid

Between 1967 and 1989, congress enacted a number of amendments to Title V, adding requirements that MCH programs work closely with Medicaid in a number of activities. The amendments are located in Title V rules at HRSA 42 USC Section 705(a)(5)(F) and can be found on the HRSA website at www.hrsa.gov/epsdt/titlev.htm#rules .

The amendments require that state Title V MCH programs:

- assist with coordination of EPSDT
 - establish coordination agreements with their state Medicaid program
 - provide a toll-free number for families seeking Title V or Medicaid providers
 - provide outreach and facilitate enrollment of Medicaid eligible children and pregnant women
 - share data collection responsibilities, particularly related to infant mortality and Medicaid
 - provide services to children with special health care needs and disabilities not covered by Medicaid
-

Integration with Early ACCESS

Congress created Part C of IDEA (Public Law 105-17: IDEA '97: Part C) to assist states to design and implement systems of early intervention services for infants and toddlers with disabilities and their families. Early intervention systems differ in many ways from state to state. The Iowa Department of Public Health is a signatory partner in building the Iowa Early ACCESS system. IDPH Title V child health contract agencies participate in the Early ACCESS system in an effort to better meet the needs of children and families. (Iowa Administrative Code 281 IAC 120.4-120.8)



104 Modernizing Public Health in Iowa

Authority: Iowa code 136 and 137; Iowa administrative code 641 IAC 77

Effective Date: January 19, 2012

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Replaces: 106 – October 2009

Public health modernization initiative

“What should every Iowan reasonably expect from local and state public health?” The Modernizing Public Health in Iowa initiative is working to advance public health in Iowa in order to answer that very question. The initiative represents a partnership between local and state public health that is defining basic standards of service delivery to all Iowans. That definition is found in the Iowa Public Health Standards.

Iowa’s approach to public health standards

The Iowa Public Health Standards apply to the governmental public health system. The standards recognize the governance responsibilities of boards of health at the state and local level in safeguarding the community's health. Compliance with the Iowa Public Health standards is voluntary.

According to the standards, local boards of health are responsible for assuring compliance with the local criteria of the Iowa Public Health Standards within their jurisdictions (city, county or district). Local boards of health designate a local public health agency to assure the standards are being met. The standards allow for local discretion on the method by which a board of health will oversee the designated local public health agency (i.e., as governing body or through contract). Local discretion is also allowed for methods by which a designated local public health agency complies with the standards (i.e., directly providing services and/or through contracts and agreements with other entities).

The State Board of Health is responsible for assuring compliance with the state criteria of the Iowa Public Health Standards. The State Board of Health will assure compliance through the Iowa Department of Public Health. The state criteria delineate state-level responsibilities for public health and, in particular, responsibilities to support local public health.

**The Iowa
Public Health
Standards**

The Iowa Public Health Standards represent the collaborative effort of over 150 local and state public health professionals and public health partners. Their combined public health expertise, scientific knowledge and practical experience provide the foundation for defining the responsibilities of governmental local and state public health.

Standards were developed in 11 component areas. The first six identify the infrastructure that must be in place to deliver public health services. These are titled organizational capacity standards. The criteria listed in the organizational capacity standards apply universally to each of the five public health service area standards.

Organizational Capacity Standards:

- Governance
- Administration
- Communication and Information Technology
- Workforce
- Community Assessment and Planning
- Evaluation

Public Health Services Standards:

- Prevent Epidemics and the Spread of Disease
- Protect Against Environmental Hazards
- Prevent Injuries
- Promote Healthy Behaviors
- Prepare for, Respond to and Recover from Public Health Emergencies

**Public Health
Modernization
Act**

The Public Health Modernization Act (PHMA) was signed into law in May of 2009. The law calls for the establishment of two advisory bodies to provide direction for the modernization initiative. The Public Health Advisory Council and Public Health Evaluation Committee are working towards the implementation of a voluntary accreditation process for Iowa's state and local governmental public health system. It is anticipated this system will begin in 2012.

More information on Modernizing Public Health in Iowa is located on the IDPH website at www.idph.state.ia.us/mphi



105 Core Public Health Functions

Authority: HRSA Maternal and Child Health Bureau (MCHB)

Effective Date: January 19, 2012

Initial Revision

Replaces: 105 – October 2008

Three core public health functions

The core public health functions described in the 1988 Institute of Medicine report, *The Future of Public Health*¹, provide the framework for the nation's public health system. The report describes the three core functions as:

- Assessment
- Policy Development
- Assurance

Ten essential services

The *Ten Essential Public Health Services to Promote Maternal and Child Health in America*² interprets the core public health functions as they relate to maternal and child health (MCH) and provides the framework for establishing program goals, activities and evaluation.

The ten essential services are:

1. Assess the status of maternal and child health at the local, state and national levels so problems can be identified and addressed.
2. Diagnose and investigate the occurrence of health problems and health hazards that impact women, children and youth.
3. Inform, educate and empower the public and families regarding

¹ Institute of Medicine. (1988). *The Future of Public Health*. Washington, DC: National Academy Press.

² Grason, H.A., Guyer B. (1995). *Public Health Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America*. DHHS, Maternal and Child Health Bureau, ASTHO, NACCHO, City Match.

maternal and child health in order to promote positive health beliefs, attitudes and behaviors.

4. Mobilize community partnerships among policymakers, health care providers, the public and others to identify and implement solutions to maternal and child health problems.
 5. Work with the community to assess the relative importance of MCH needs based on scientific, economic and political factors; and provide leadership for planning and policy development to address priority needs.
 6. Promote and enforce laws, regulations, standards and contracts that protect the health and safety of women, children and youth and that assure public accountability for their well-being.
 7. Link women, children, youth and families to needed population-based, personal health and other community and family support services; and assure availability, access and acceptability by enhancing system capacity, including directly supporting services when necessary.
 8. Assure the capacity and competency of the public health and personal health work force to effectively address MCH needs.
 9. Evaluate effectiveness, accessibility and quality of personal health and population-based MCH services.
 10. Conduct research and support demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.
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106 Organizational Structure

Authority: Iowa department of public health executive team; Iowa administrative codes 641 IAC 77, 641 IAC 79, 641 IAC 80.
Effective Date: January 19, 2012
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Replaces: 104 – October 2008

The Maternal and Child Health program is administered by the Iowa Department of Public Health, Division of Health Promotion and Chronic Disease Prevention, Bureau of Family Health, pursuant to an agreement with the United States Department of Health and Human Services, Health Resources and Services Administration. State funds are appropriated and applied as federal match.

Iowa Department of Public Health

Under the leadership of the director, the Iowa Department of Public Health (IDPH) exercises general supervision of the state's public health; promotes public hygiene and sanitation; conducts health promotion activities; prepares for and responds to bioemergency situations; and, unless otherwise provided, enforces laws on public health.

The Iowa Department of Public Health's programs are conducted through the executive staff and the following six divisions:

- Acute Disease Prevention and Emergency Response
- Administration and Professional Licensure
- Behavioral Health
- Environmental Health
- Health Promotion and Chronic Disease Prevention
- Tobacco Use Prevention and Control

The Director's Office focuses primarily on the overall development of health-related policy, strategic planning and outcome.

The Iowa State Board of Health is the policy-making body for the IDPH. It has the powers and duties to adopt, promulgate, amend and repeal rules and regulations, and advises or makes recommendations to the governor, general assembly and the IDPH director, on public health, hygiene and sanitation. Additional information on IDPH and its

programs is available on the Iowa Department of Public Health website at www.idph.state.ia.us.

Division of Health Promotion and Chronic Disease Prevention

The Division of Health Promotion and Chronic Disease Prevention promotes and supports healthy behaviors and communities, the prevention and management of chronic diseases, the development of public health infrastructure and access to health care/services at local and state levels. The division has seven components:

- Bureau of Chronic Disease Prevention and Management
 - Bureau of Family Health
 - Bureau of Oral and Health Delivery Systems
 - Bureau of Local Public Health Services
 - Bureau of Nutrition and Health Promotion
 - Office of Minority and Multicultural Health
 - Office of Health Care Transformation
-

Bureau of Family Health

The Iowa legislature designated the Iowa Department of Public Health (IDPH) as the administrator for Title V MCH services and directed IDPH to contract with the University of Iowa Department of Pediatrics, Child Health Specialty Clinics (CHSC) as the state's Title V provider for Children and Youth with Special Health Care Needs (CYSHCN) program. The Bureau of Family Health is responsible for administering the MCH program and also a portion of Title X Family Planning services in Iowa.

The bureau uses core public health functions to fulfill its responsibility for infrastructure building, population-based services, enabling services and direct health care services directed toward the health of women and children. The bureau has primary responsibility for system planning, program development and evaluation; developing and monitoring standards of care; and coordinating health-related services between and among community-based entities serving Iowa families.

The bureau has multiple programs focusing on the health of children and families, including the following: Maternal and Child Health Title V programs, Healthy Child Care Iowa, Early Childhood Comprehensive Systems grant, 1st Five, Early ACCESS, *hawk-i* Outreach, Early Periodic Screening Diagnosis and Treatment (EPSDT), Family Planning, Early Hearing Detection and Intervention, Iowa Infant Mortality Prevention Center, school health programs, home visiting programs, the Statewide Perinatal Care Program and the programs of

the Center for Congenital and Inherited Disorders. The bureau works closely with other state departments to accomplish the health-related goals for Iowa families.

Bureau of Oral and Health Delivery Systems

The Bureau of Oral and Health Delivery Systems includes the Oral Health Center that is responsible for the core public health functions of assessment, policy development and assurance of oral health services in the state. Bureau staff provides consultation and training for programs targeting pregnant women, infants, children and youth. Programs focus on preventing dental disease and promoting oral health for all Iowans. The bureau oversees new and existing oral health programs including the following: Title V maternal and child oral health, including the Medicaid and EPSDT oral health programs; school-based sealant programs; and the I-Smile™ Program. The bureau serves as a resource for the Bureau of Family Health.

In addition, the bureau advocates for quality health care delivery systems for all Iowans and provides information, referrals, education, grant opportunities, technical assistance and planning for Iowa communities. The bureau is designated as the state entity for addressing rural health and primary care issues in Iowa and works to improve access to health care for vulnerable populations. The bureau houses the Primary Care Office, the State Office for Rural Health and Primary Care and the Iowa Health Workforce Center. Other programs within the bureau include the following: Iowa Medicare Rural Hospital Flexibility Program, the State Loan Repayment Program (PRIMECARRE), the Volunteer Health Care Provider Program and the Small Hospital Improvement Program (SHIP).

Bureau of Chronic Disease Prevention and Management

The Bureau of Chronic Disease Prevention and Management supports the development and implementation of services that prevent chronic disease and/or assist in the management of chronic disease. The bureau administers two programs funded by the Centers for Disease Control and Prevention that provide direct screening services to eligible Iowa women, i.e., Breast and Cervical Cancer Early Detection Program (BCCEDP) and the WISEWOMAN Cardiovascular Research Study. The bureau is an active partner in the Iowa Consortium for Comprehensive Cancer Control.

Bureau of Local Public Health

The Bureau of Local Public Health Services provides leadership at the local level in the development of the public health infrastructure. The bureau provides leadership at the state and local levels for the

Services

development and implementation of designated programs within the IDPH. Staff is responsible for oversight of the state allocations for board of health infrastructure, public health nursing, home care aide and senior health. Staff provides regional on-site technical assistance and professional consultation to local public health professionals who manage the provision of population focused, community-based services and the delivery of personal health care in clinic or home settings. Technical assistance activities address community assessment, policy development, program planning and evaluation, education of local staff, data collection and analysis, allocation of funds and promotion of health services. Staff also works with community-based groups for community health development and health planning. The bureau assures compliance with grant contract conditions and current rules with the contractors (boards of health or boards of supervisors) and all subcontractors funded with state appropriations for the programs. Iowa Administrative Code 641 IAC 77, 641 IAC 79, 641 IAC 80 and 641 IAC 83 designate the accountability the agencies have when utilizing the funding. Bureau staff is responsible for technical assistance and education for agencies providing the well-being visits under the Family Investment Program.

**Office of
Minority and
Multicultural
Health**

The Iowa Department of Public Health has designated a consultant to address minority and multicultural population health issues. In cooperation with other IDPH bureaus, the consultant develops cooperative and collaborative data collection, networking and resource sharing. The consultant's activities focus on programs within IDPH and outreach to communities. Technical assistance is provided in outreach, content area, awareness, resources and program development.

The Refugee Health Program goal is to ensure a complete health assessment for each newly arriving refugee and assist health-care providers and refugees in the management of any identified health problems. The program staff monitors health assessments and follow-up care and provides necessary assistance. The completed Iowa Refugee Health Assessment form identifies medical test results, dental status, immunization status and the need for referral or follow-up services. Information from this form is used for management purposes and to coordinate program activities.

**Bureau of
Nutrition and
Health
Promotion**

The Bureau of Nutrition and Health Promotion administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Food Stamp Nutrition Education Plan, the Cardiovascular Risk Reduction grants, the 5 Plus 5 Nutrition and Physical Activity

program, the Iowans Fit for Life program and the Community Transformation grants. The bureau serves as a resource for the Bureau of Family Health by providing nutrition consultation and training for MCH and WIC contract agencies. The bureau is involved in the planning and implementation of the nutrition services within the Maternal and Child Health programs. The bureau also coordinates with Child Health Specialty Clinics and other nutrition providers.

The Food Stamp Nutrition Education Plan includes the Iowa Nutrition Education Network, the Pick A Better Snack Social Marketing Campaign and approximately 25 community grants for nutrition education and physical activity for low-income families.

The Cardiovascular Risk Reduction activities support community-based approaches that focus on populations at greatest risk - women; young adults aged 18 through 24; blue-collar workers; and African-American, Hispanic/Latino and Native American Indian populations.

The 5 Plus 5 Nutrition and Physical Activity program targets Iowa families through community-based events and activities. Special emphasis is placed on programs that support residents in rural areas.

Other state departments

Programs of other departments or entities of state government that serve Iowa families include, but are not limited to, the following:

The Iowa Department of Human Services administers services for mental health, mental retardation, developmental disabilities, child welfare, child care, child abuse and neglect, the Title XIX (Medicaid) program, the Title XX block grant, Title XXI state child health insurance program and pregnancy prevention grants.

In addition to primary and special education programs, the Department of Education administers the child and adult care food program, school breakfast and lunch programs, grants for at-risk youth programs, human development curriculum, grants for child development programs for at-risk three-to-five-year-olds and their families, and school health nursing consultation. The Department of Education also houses the Head Start Collaboration Office.

The Department of Management, Early Childhood Iowa Office is responsible for carrying out the activities of Iowa's comprehensive early care, health and education system.

Section 200

Grant Management

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201 Grant Application

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76.9(135)
 EFFECTIVE DATE: JANUARY 19, 2012
 INITIAL REVISION
 REPLACES: 201—OCTOBER 2008

Grant application

The Iowa Department of Public Health periodically solicits proposals to select the most qualified applicants to provide public health services at the community level for Child Health (CH) (including Oral Health and *hawk-i*), Maternal Health (MH) and Family Planning (FP). This is accomplished through a competitive request for proposal (RFP) for a multi-year project period. Throughout the project period, annual continuation applications are required. Contracts are issued for one-year increments based on a review of the continuation application, MCH contract agency performance and compliance with both general and special conditions of the contract.

The Iowa Department of Public Health is committed to ensuring that all of Iowa's pregnant women, children and families have access to quality health services. CH, MH and FP programs are more likely to succeed in this mission if they are flexible, integrated, family-centered and community-based. The Iowa Administrative Code 641 IAC 76 identifies the application process.

Program integration

To accomplish program integration at the community level, IDPH and state agency partners have elected to integrate additional programs into MCH services through the RFP/RFA process. These programs include, but are not limited to:

- EPSDT
- Medicaid enhanced services for pregnant women (including presumptive eligibility)
- *Hawk-i* outreach (including presumptive eligibility)
- Early ACCESS
- Healthy Child Care Iowa

Local child health contract agencies have the responsibility to integrate with the lead and immunization programs in the service area.



202 Contracts and Subcontracts Management

AUTHORITY: 7CFR 246.3; IOWA ADMINISTRATIVE CODE 641 IAC 76.13(5)
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 202—OCTOBER 2008

Contracts

All parts of the application for Title V MCH related program funding are part of the contract between a local agency and IDPH. By executing a contract, the local agency adopts the provisions and requirements set forth in the RFP for the project period and the initial contract year and the RFA specific to that contract year.

The contract includes both general conditions and special conditions. The general conditions apply to all contracts issued by the Iowa Department of Public Health (IDPH). The IDPH general conditions are located on the IDPH website at www.idph.state.ia.us (under “funding opportunities”) The special conditions are specific to the program covered by the contract. All MCH contract agencies and their subcontractors are required to follow both sets of conditions and these conditions are included in administrative review audits.

Subcontracts

MCH contract agencies may subcontract a portion of the project activity to another entity. If the subcontract is over \$2,000 it must be approved by IDPH in writing and in advance of execution of the subcontract.

Subcontractors must follow the same state and federal regulations required of the MCH contract agency. The MCH contract agency is responsible for ensuring the compliance of the subcontractor. The subcontract must include personnel training, documentation requirements, record retention, payment for services rendered and ongoing communication of regulations. Section five of the IDPH general conditions, located on the IDPH website at www.idph.state.ia.us (under “funding opportunities”) contains the required components of a subcontract.

If an MCH contract agency exchanges personnel services with another entity, a written legal agreement describing the exchange is required.

Grant Management

At a minimum, the agreement should address the scope of work to be performed, assurance of qualified personnel, financial exchange, reporting requirements and time period.

The subcontractor must report all program income generated by the subcontract to the MCH contract agency. The MCH contract agency is required to report the program income balance of subcontracts on a monthly basis to IDPH.

The MCH contract agency and subcontractor must execute a subcontract annually following review by IDPH. The MCH contract agency must maintain written documentation regarding the annual subcontract and have the documentation available for IDPH review.

**SharePoint
Service
Contract
Center**

The IDPH SharePoint Service Contract Center is used for execution, management and monitoring of documents for IDPH service contracts awarded following an RFP/RFA process. After an MCH contract is awarded, a specific and unique SharePoint contractor site is established for the legal entity identified as the MCH contract agency on the face page of the contract. Documents maintained within the agency's secure site include, but are not limited to, the approved application, service contract and associated amendments, SharePoint user memorandum of understanding (MOU) and associated modifications, business organization form, expenditure reports and additional contractually required reports.



203 Contract Revisions

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76.9(135)
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 203—OCTOBER 2008

Components All components of the agency’s grant application are part of the contract between an MCH contract agency and IDPH. This includes the budgets, activity worksheets and service delivery tables. Any program changes require a written revision to the approved application component.

Request for change The formal request for approval of program changes must be submitted in writing to the agency’s consultant in the Bureau of Family Health and/or the Oral and Health Delivery System and approval must be granted before changes are implemented.

The process for requesting a program change is as follows:

1. The agency will submit the request in writing to the consultant describing the requested program change, the justification for the change and supporting documentation.
 2. The consultant will review the proposed changes and provide feedback to the agency.
 3. An email will be sent to the agency from the consultant, or other directed staff, to notify the agency of the request status.
 4. Upon approval, the agency will upload the most current version of the program document(s) into the SharePoint Service Contract Center.
-



204 Equipment

AUTHORITY: IOWA ADMINISTRATIVE CODE 401 IAC 7.4(1)

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 204—OCTOBER 2008

Definition

The IDPH general conditions, located on the IDPH website at www.idph.state.ia.us (funding opportunities) define equipment as any item having a useful life of one year or more and a unit acquisition cost of \$5,000 or more.

Items such as office supplies, medical supplies and computer hardware and software supplies generally do not meet this definition of equipment and are considered supplies.

If an MCH contract agency desires to purchase equipment that was not approved as part of the current application budget line item, a letter requesting permission for the purchase must be sent prior to purchase to:

Chief, Bureau of Family Health
Iowa Department of Public Health
321 East 12th Street
Lucas State Office Building
Des Moines, IA 50319-0075

Funds may not be used to purchase motor vehicles.

Equipment acquisition form

Within one month of purchase the MCH contract agency must complete an Equipment Acquisition Form. The request for reimbursement for the equipment purchase should be included in the Electronic Expenditure Workbook on the SharePoint Service Contract Center or submitted on a hard copy General Accounting Expenditure (GAX) form. Forms and invoices must be submitted to the fiscal manager for the Bureau of Family Health.

When completing the Equipment Acquisition Form, the MCH contract agency must include the following items:

- Description of the equipment to be added
- Serial number (if applicable)
- Date of acquisition
- Physical location of item
- Acquisition cost
- Invoice number
- Inventory number
- Program for which the equipment is intended
- Program that purchased the equipment (CH or MH)

The Equipment Acquisition Form and General Accounting Expenditure (GAX) Form are located in appendices A4 and A5 of this manual.

Submit the Equipment Acquisition form with the completed GAX to:

Contract Manager
Bureau of Family Health
Iowa Department of Public Health
321 East 12th Street
Des Moines, IA 50319-0075

Inventory

The Iowa Department of Public Health maintains an inventory of each MCH contract agency's fixed assets. IDPH inventory listings are reconciled annually with the MCH contract agency's inventory. The Bureau of Family Health will conduct an inventory audit in conjunction with the bi-annual administrative on-site review. All, or a sampling, of the equipment listed on the IDPH electronic inventory will be required to be accounted for upon request.

Disposal of property purchased in whole or in part with grant program funds requires prior written authorization of the Bureau of Family Health. Authorization for disposal must be obtained regardless of the method of disposal, i.e. donated, sold, traded-in, discarded.

MCH contract agencies may request to delete equipment from their inventories if the equipment has been lost, stolen, broken, is obsolete or no longer meets the definition of equipment as defined in this policy. The executive director must submit a written request by letter or authorized email requesting the removal and giving the reason for removal to the chief of the Bureau of Family Health. The bureau will send a written approval to the executive director.

The Equipment Inventory Form is located in appendix A6 of this manual.



205 Request for Exception to Policy

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 206—OCTOBER 2008

Exception to policy

If an MCH contract agency is unable to meet a specific contract requirement, it may choose to request an exception to policy related to that requirement. The request for exception to policy must be submitted in writing to:

Chief, Bureau of Family Health
Iowa Department of Public Health
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0075

The agency's request for exception to policy will be considered by IDPH leadership in consultation with the state attorney general's office, when appropriate.

Process and decision

The written request for exception to policy must contain the following components:

- Reason for requesting an exception to policy
- Rationale for inability to demonstrate compliance with the contract requirement
- Length of time for which the exception to policy is requested
- Work plan with definitive steps toward compliance with the contract requirement, including target dates and responsible personnel
- Signature of the executive director of the agency requesting the exception to policy.

IDPH reserves the right to specify the format for reporting. However, in the absence of a prescribed format, the MCH contract agency will include the above components in letter format.

The chief of the Bureau of Family Health (BFH) will process the request and make decisions regarding the acceptance or denial of the request for exception to policy. The chief will notify the agency executive director of the decision in writing. The timetable for achieving compliance with the contract requirement may be negotiated between the BFH chief and the MCH contract agency executive director.

The exception to policy may be approved for up to one year, unless a different time limitation is stated in the specific contract requirement. MCH contract agencies requiring an extension of an approved exception to policy must provide, in writing, the rationale for the extension request to the BFH chief.

Appeal

Failure to request an exception to policy for a contract requirement may result in the reduction or elimination of an MCH contract agency's funding. Failure to demonstrate satisfactory progress toward an approved work plan may result in the reduction or elimination of funding through the Bureau of Family Health. An MCH contract agency facing reduction or elimination of funding will be notified in writing by the BFH chief.

MCH contract agencies have the right to appeal decisions rendered as a result a request for exception to policy per the Iowa Administrative Code 641 IAC 76.

Section 300
Program Administration

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301 Maternal and Child Health Services

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Sec 506 [42 USC 706]
Effective Date: January 19, 2012
Initial Revision
Replaces: 301 – October 2008

Purpose

Maternal and Child Health (MCH) programs promote the development of the local system of care for pregnant women, children from birth through age 21 years and their families. MCH programs provide services that are family-centered, community-based, collaborative, comprehensive, flexible, coordinated, culturally competent and developmentally appropriate. MCH programs promote the core public health functions of assessment, policy development and assurance.

Goals

The purpose of the MCH program is to:

- Promote the health of mothers and children by ensuring access to quality MH and CH preventive health services (including oral health care), especially for low-income families or families with limited availability of health services
 - Reduce infant mortality and the incidence of preventable diseases and disabling conditions
 - Increase the number of children appropriately immunized against diseases
 - Promote the development of community-based system of care, including oral health care, for pregnant women, children and their families
 - Partner with other public health entities to assure services are available to pregnant women, children and their families
-

Components

MCH programs address infrastructure building services, population-based services, enabling services and access to direct health services in accordance with Iowa Administrative Code 641 IAC 76 located in appendix A2 of this manual.

These components are illustrated in the MCH Pyramid of Core Public Health Services located in appendix A8 of this manual.

Infrastructure building services

Infrastructure building services are activities that support the development and maintenance of comprehensive health services systems. Examples include:

- Assessment of community needs and assets
 - Data collection and analysis
 - Program planning
 - Policy development
 - Establishing community linkages including those with private practitioners
 - Facilitating interagency coordination
 - Developing and monitoring protocols
 - Cost analysis
 - Program evaluation
 - Performance management
 - Professional development and training
 - Support for innovative initiatives
-

Population-based services

Population-based services provide preventive interventions and personal health services for groups of people, rather than in one-on-one situations. The client's payer source is not assessed and services for individuals are not billed. Population-based services may be provided to an entire community, county or region. Examples include:

- Newborn screening services
 - Immunization clinics
 - Lead testing clinics
 - Oral screenings for the school screening requirement
 - Community screening for substance abuse and/or domestic violence
 - Breastfeeding promotion and support
 - Health education for groups of individuals
 - Sudden Infant Death Syndrome (SIDS) awareness
 - Prenatal health education classes
 - Parent education classes
 - Injury prevention education
 - Child care and school health education
 - Other public health awareness campaigns
-

Enabling services

Enabling services assist families to access services. Examples include:

- Outreach for health care coverage including Medicaid and *hawk-i*
 - Presumptive eligibility determinations for pregnant women and children
 - Assisting families in establishing health homes
-

- Informing services for newly Medicaid enrolled children
- Care coordination services for Medicaid and non-Medicaid enrolled women and children including home visits for care coordination*
- Reminding families that periodic screens are due
- Assisting families to access support services including transportation to medical/dental/mental health providers and interpreter services for medical/dental/mental health services
- Service coordination for selected populations in the Early ACCESS program (e.g. children with lead levels of 20 µg/dL or greater)

**Care coordination* links families to needed medical, dental, mental health and other services. Care coordination assures timeliness, appropriateness and completeness of care by:

- Promoting continuity of care among providers and between services
- Acting as an advocate for the family
- Providing support and health information
- Consulting with or referring to others within an interagency team
- Working collaboratively with the client, family member or other providers to attain goals that are mutually agreed on
- Following up to assure that clients received services

Direct health care services

Direct health care services include gap-filling routine ambulatory preventive medical and oral health care. For the purposes of the MCH program, direct health care services include any billable service to the Iowa Medicaid Enterprise (IME) under the Screening Center (Child Health) and Maternal Health Center provider status. Direct care services provided by MCH contract agencies are available to both Medicaid and non-Medicaid enrolled clients. Examples of direct care services include:

- Child Health – a complete well-child screen or any component of the well-child screen provided in a clinic setting such as developmental screens, lead tests, immunizations, nutrition counseling, transportation, interpretation and nursing/social worker home visits
- Maternal Health –medical prenatal care for pregnant women including services such as health education, nutrition education, postpartum home visits, transportation and interpretation
- Oral Health – preventive oral health services such as screenings and fluoride varnish applications

Ideally, direct health care services for MCH clients are accessed through agreements established with medical and dental practitioners at the local level. However, preventive direct health care services may be supported by MCH program funds in areas where gaps in service provision are clearly identified.

MCH contract agencies proposing to provide direct antepartum and postpartum medical care (MH) and/or full well child exams (CH) must demonstrate that provider availability or other barriers exist. Examples include:

- Designated medically underserved area or health care professional shortage area
- Lack of pediatricians and/or family practice physicians in the service area
- Lack of practitioners willing to serve Medicaid eligible children or children who are uninsured / underinsured
- Lack of health care professionals to provide prenatal care to Medicaid eligible women or women who are uninsured / underinsured
- Lack of dentists willing to serve Medicaid eligible clients or clients who are uninsured /underinsured
- Medically underserved populations

Services provided by MCH contract agencies are subject to the policies, procedures, rules and regulations contained within the MCH Administrative Manual regardless of the source of funds. The MCH contract agency and its subcontractors may not claim exemption to IDPH policy and procedure requirements based upon the payment source for the services provided.

Direct care and FQHCs / RHCs

MCH contract agencies that are Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs) must emphasize infrastructure building and enabling activities that involve collaboration with medical and dental practices within the service area. Efforts must be made to encourage and recruit private practices within the service area to provide services for low-income women and children, both uninsured / underinsured and those enrolled in Medicaid.

For MCH contract agencies that are FQHCs or RHCs, MH and CH (including OH), grant funds and/or associated program income **may not** be used to support *direct health care services* provided by the FQHC or RHC. MH and CH programs are encouraged to refer clients to the clinical operations (direct care arm) of FQHC or RHC clinics, as well as to private medical and dental providers, for direct care services. Revenue generated by MH, CH and OH programs **must** be used to enhance the respective programs, e.g., informing, care coordination, oral screenings and local transportation services.

Medicaid HMOs

Clients enrolled in a Medicaid health maintenance organization (HMO) must access services from a medical provider within the Medicaid

HMO panel. Direct care services provided by a physician or nurse practitioner outside of the HMO panel of providers are not covered by Medicaid.

- Medicaid HMO clients may receive presumptive eligibility, informing and care coordination services from an MCH contract agency, and the agency may bill IDPH for these services.
 - Dental services remain fee-for-service. Dental services are not impacted by a client's Medicaid HMO status.
-



302 Community Linkages

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Sec 506 [42 USC 706]
Effective Date: January 19, 2012
Initial Revision
Replaces: 302 - October 2008

Definition

Community linkages foster the sharing of resources, responsibility and accountability for assuring comprehensive, broad-based improvement of health status in the community. The Iowa Department of Public Health advocates a system of care at the local level that minimizes barriers to care, focuses on comprehensiveness of care, prevents duplication, reduces fragmentation and reduces cost. This may be accomplished by developing linkages with other community partners for a variety of purposes such as communication, integration of multiple services within one agency or cooperative agreements with other providers.

Regardless of the purpose, the partnership should foster services that are complementary, provide for continuity and are delivered in a timely fashion. Since communities are unique, the strategies used to achieve an integrated or coordinated system of services should be based on the resources, demographics and culture of the community as well as the missions of the service providers.

Board of health linkage

The MCH contract agency will link with the local board of health in each county where services are provided. There are a variety of strategies that agencies can use to link with the local boards of health, such as regular attendance at board meetings or periodic inclusion on the board agenda. Specific linkage strategies may be determined locally with input from both agency and board.

The MCH contract agency will assure that the local board of health has been actively engaged in planning for, and evaluation of, services. It will also maintain effective linkages with the local board of health, including timely and useful communications and ongoing collaboration.



303 Policies and Procedures

Authority: Iowa Administrative Code 641 IAC 76 (135)

Effective Date: January 19, 2012

Initial Revision

Replaces: 303 – October 2008

Requirements Each MCH contract agency is required to have policies and procedures documented that guide the administration and operations of the Maternal and Child Health programs. These policies and procedures will comply with federal regulations as well as state laws and guidelines.

A policy should state the course of action the organization wants to pursue. Procedures describe actions or tasks necessary to meet a specific policy. Policies and procedures must be made available to appropriate staff.

Policies and procedures should be reviewed and revised annually, or according to agency policy, and no less frequently than every three years. Agencies reviewing policies less than annually must specify the frequency in agency policy. An effective revision date should be noted on each policy.

IDPH conducts an administrative on-site review of each agency at least every other year to monitor compliance with the required policies and procedures. Appendix A10 of this manual contains the review checklist.

**Required
general
administration
policies**

- Compliance with the Americans with Disabilities Act (ADA) of 1990 and amendments and Section 504 of the Rehabilitation Act of 1973
- Compliance with the Drug Free Workplace Act of 1988
- Compliance with Public Law 103-227 (Pro –Children Act of 1994) and Iowa's Smokefree Air Act (Iowa Code chapter 142D)
- Emergency
 - Fire
 - Weather

- Client emergency
 - Disruptive and/or violent behavior
 - Biological terrorism or threat
 - Employee/personnel based OSHA requirements including:
 - Right to know
 - Bloodborne pathogen standards
 - Hepatitis B immunization
 - Exposure control plan (including infectious disease and hazardous chemicals)
 - Employee training plan (based on OSHA requirements)
 - Integration of services
 - Organizational chart
 - Personnel including:
 - Civil rights, nondiscrimination and Affirmative Action
 - Communication methods
 - Conditions of employment
 - Employee orientation program
 - Employee performance evaluation
 - Fringe benefits
 - Grievance procedures
 - Job description (including qualifications, credentials, licensure, direct supervision of paraprofessionals providing informing and care coordination services)
 - Leave and absence
 - Provisions for career development or continuing education, including attendance at professional development activities to promote the cultural and linguistic competence of staff
 - Salary schedules
 - Timesheets
 - Reporting changes in MCH contract agency location, key personnel and services to IDPH
 - Quality assurance / quality improvement
-

**Required
fiscal policies**

- Accounting standards
- Approval authorities
- Bad debt write off
- Billing procedure (includes IDPH fee-for-service, Title XIX, Title XX, client fees, other third-party payers and other funding sources)
- Continuous daily time studies
- Expenditure reports
- Inventory management
- Lines of responsibility
- MCH cost analysis

- Method for determining administrative or indirect costs
 - Payment schedule
 - Purchasing procedures
 - Record-keeping requirements
 - Segregation of duties
 - Sliding-fee scale
-

Required client-based policies (dependent on level of services provided)

- Acceptable abbreviations in client records
 - Appointment system
 - Child abuse reporting
 - Client civil rights
 - Client eligibility
 - Client record maintenance
 - Client referrals
 - Clinic protocols
 - Confidentiality (including compliance with HIPAA)
 - Consumer input / consumer satisfaction
 - Control of inventories (supplies and medication)
 - OSHA requirements including:
 - Right to know
 - Bloodborne pathogen standards
 - Hepatitis B immunization
 - Patient consent
 - Patient fees (including billing and collection)
 - Product selection and evaluation
 - Purchasing
 - Retention of records
 - Security of records
 - Supply distribution
-

Required community-based policies

- A policy will be in place that specifies how responsibilities are shared among community partners for:
- Communicable disease outbreak
 - Communicable disease follow-up (on individual client)
 - Immunization services
 - Lead testing (including environmental and educational follow-up)



304 Personnel

Authority: Iowa Administrative Code 641 IAC 76(135); contract general conditions
Effective Date: January 19, 2012
Initial Revision
Replaces: 304 -October 2009

Competencies A broad range of competencies are required of personnel to carry out MCH infrastructure building services, population-based services, enabling services and direct health care services. MCH contract agencies will secure and retain personnel or subcontractors with expertise in business administration, quality assurance and improvement, health policy development, information systems, community systems building, population diversity and maternal and child health clinical care.

Requirements There are a variety of models for delivering quality MCH services. Each MCH contract agency must design a personnel structure that fits the business plan of the organization and reflects its own unique needs and resources. Personnel resources can be maximized to provide quality services by using a variety of disciplines in creative ways, by integrating services with other programs such as WIC and/or by contracting with other agencies and private providers.

IDPH reserves the right to inquire at any time about the staffing assignments and credentials of any professional person with direct responsibilities in the MCH programs. The MCH contract agency is required to satisfy the minimum staffing and credentialing requirements of IDPH. If IDPH questions the time allocations and staffing assignment ratios of a staff person or persons, the MCH contract agency may be required to supply documentation in the form of time studies, direct hours billed or staff timesheets.

Fringe benefits Personnel whose salaries are supported in part or in full by the MCH contract must receive the same package of fringe benefits available to other employees of the MCH contract agency.

Fringe benefits may only be requested on that portion of the employee's salary supported by the MCH contract and must be based

on the salary rate identified in the MCH application.

The fringe benefits provided must be identified in the written personnel policies.

Job descriptions

The MCH contract agency is required to have written job descriptions available on-site for all positions. Each job description must specify the duties of the position. Job descriptions must be in compliance with the applicable Iowa Code for scope of practice of each staff person who is licensed by the state. The MCH contract agency is responsible for assuring that all persons, whether employees, agents, subcontractors or anyone acting on behalf of the MCH contract agency, are properly licensed, certified or accredited as required under applicable state law. The MCH contract agency must provide standards of practice for service providers who are not otherwise licensed, certified or accredited under state law or administrative code.

Excluded providers

Exclusion of Certain Individuals from Participation in Medicare and State Health Care Programs:

MCH contract agencies are required to check the Medicaid/Medicare program exclusion status of individuals and entities prior to entering into employment or contractual relationships. IDPH supports efforts to prevent Medicaid/Medicare fraud by requiring MCH contract agencies to assure that newly hired employees are not listed as an excluded provider. The basis for exclusion includes convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.

For exclusions implemented prior to August 4, 1997, the exclusion covers the following Federal health care programs: Medicare (Title XVIII), Medicaid (Title XIX), Maternal and Child Health Services Block Grant (Title V), Block Grants to States for Social Services (Title XX) and State Children's Health Insurance (Title XXI) programs.

For exclusions implemented after August 4, 1997, this program includes Medicare, Medicaid and all other plans and programs that provide health benefits funded directly or indirectly by the United States.

The effect of an exclusion (not being able to participate) is:

- No payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity. Federal health care programs include Medicare, Medicaid and all other plans and programs that

- provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).
- No program payment will be made for anything that an excluded person furnishes orders or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.
 - There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room.

An MCH contract agency employing or contracting with an excluded individual may be subject to civil monetary penalties and other damages for each service provided to clients.

Resources include the following:

- Guidance is found in the Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs. This publication is provided by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and available on the HHS-OIG website at www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm
- Guidance from CMS is found in a January 16, 2009 State Medicaid Director Letter (SMDL #09-001) at www.cms.hhs.gov/SMDL/downloads/SMD011609.pdf
- A reminder for all providers is located in the April 8, 2011 IME Informational Letter #1001 located at www.ime.state.ia.us/docs/1001_ExclusionfromParticipationinFederalHealthCarePrograms.pdf
- Information regarding whether an individual or entity is excluded is found on the HHS-OIG website at www.exclusions.oig.hhs.gov/ .
- An additional listing of parties excluded from any federal payment is found in the Excluded Parties List System (EPLS) website at www.epls.gov/ .

**Executive
director**

The executive director is responsible for supervisory and contract management tasks related to the programs included in the application. Communications regarding the MCH contract will be sent to the executive director. It is the responsibility of the executive director to appropriately disseminate information to the MCH contract agency's board chair, project director and program coordinators. The board chair, project director and program coordinators may be sent information related to the contract at the discretion of the Iowa

Department of Public Health.

Supervisory

The executive director's supervisory responsibilities include but are not limited to:

- Providing direction for planning, developing and evaluating the program
- Overseeing the annual program and budget application
- Assuring that written agency policies and procedures meet state and federal regulations
- Supervising the project director and program coordinators

Contract management

The executive director's contract management responsibilities include but are not limited to:

- Monitoring progress toward meeting program goals and budgeted expenditures
- Coordinating program activities with other agency programs
- Serving as contract administrator including signing all correspondence relating to the contract and budget
- Ensuring that agency accounting methods meet federal and state guidelines
- Serving as a liaison between the programs and the agency board of directors and/or LBOH
- Developing and managing subcontracts

Reporting

The executive director reports directly to the agency board of directors or the local board of health.

Project director

Persons hired to perform activities of a project director are required to have a minimum of six months experience in health or human services. Experience in community or public health is preferred. They are also required to possess at least one of the following:

- Bachelor's degree in a health or human services field
- Current license as a registered nurse (RN) with a bachelor's degree in any field
- Current license as an advanced registered nurse practitioner (ARNP)

An individual who has served in the capacity of project director prior to October 1, 1995, will be considered qualified to continue in that position.

The project director is responsible to the executive director of the agency and receives technical assistance from staff of the IDPH

Division of Health Promotion and Chronic Disease Prevention.
The project director has administrative and supervisory responsibilities for the following areas of program management:

Grant development

The project director's grant development responsibilities include, but are not limited to:

- Fostering coordination among local CH/FP/MH/OH/WIC programs,
- Interpreting state and federal guidelines
- Developing the agency budget in compliance with state and federal guidelines
- Developing agency quality assurance plans including providing leadership for the agency chart audit team and other related monitoring activities
- Interpreting data system reports
- Participating in community needs assessment in the agency service area
- Ensuring completion of activity worksheets on file with IDPH

Contract management

The project director's contract management responsibilities include, but are not limited to:

- Attending meetings and workshops relevant to program operations
- Ensuring compliance with state and federal guidelines
- Overseeing accurate completion of all agency reports and records
- Overseeing contractual relationships with health providers and providing training to these groups
- Ensuring timely submission of program data as outlined in the contract
- Providing written notice of contract changes
- Ensuring progress on program plan on file with IDPH
- Monitoring compliance with grant activities and submitting changes to IDPH if necessary

Program development and coordination

The project director's responsibilities for program development and coordination include, but are not limited to, supervising program coordinators in:

- Ensuring coordination of services
- Ensuring referral of participants to other sources of health care as needed
- Ensuring documentation and follow-up of all referrals
- Implementing quality improvement initiatives
- Assisting the local board(s) of health in the performance of the core public health functions of assessment, assurance and policy

development

Outreach

The project director's outreach responsibilities include, but are not limited to:

- Serving as a health professional representing the program to the public
- Providing program information to interested professionals, outside agencies, organizations and individuals
- Directing and assuring an effective referral system for outreach activities

Supervisory

The project director's supervisory responsibilities include, but are not limited to:

- Supervising both professional and non-professional agency staff
- Recruiting, training and monitoring all personnel, including outreach workers and project volunteers, to the extent that they are involved in the programs
- Overseeing organization and management of all clinic sites, including determination of location, hours of service and scheduling

MH or CH program coordinator

Persons hired to perform activities of a MH or CH program coordinator are required to have a minimum of six months experience in health or human services. Experience in community or public health is preferred. They are also required to possess at least one of the following:

- Bachelor's degree in a health or human services field
- Current license as a registered nurse (RN) with a bachelor's degree in any field
- Current license as an advanced registered nurse practitioner (ARNP)

An individual who has served in the capacity of program coordinator prior to October 1, 1995, will be considered qualified to continue in that position. The program coordinator is responsible to and carries out activities as directed by the executive director and project director.

Fiscal officer

The fiscal officer is responsible to and carries out activities as directed by the executive director and project director. The fiscal officer is responsible for management of accurate accounting for grant and other funds, using generally accepted accounting principles and requirements of appropriate Federal Office of Management and Budget (OMB) circulars.

EPSDT coordinator

Persons hired to perform activities of an EPSDT coordinator are required to possess at least one of the following:

- Current license as a registered nurse (RN)
 - Current license as a registered dental hygienist (RDH)
 - Bachelor's degree in health education, social work, counseling, sociology or psychology
-

Care coordinator

Staff providing care coordination services are required to possess at least one of the following:

- Current license as a registered nurse (RN)
 - Current license as a registered dental hygienist (RDH)
 - Bachelor's degree (or higher) in social work, counseling, sociology, family and consumer sciences, health and human development, health education, individual and family studies or psychology
 - Current license as a licensed practical nurse (LPN) or paraprofessional working under the direct supervision of a health professional listed above
-

Child care nurse consultant

Child care nurse consultants (CCNC) are required to possess at least one of the following:

- Current license as a registered nurse (RN) with a bachelor's degree
- Current license as a registered nurse (RN) with two years of experience in public health, maternal and child health, Head Start or school nursing

Additionally, the CCNC must demonstrate enrollment in, or successful completion of, the Iowa Training Project for Child Care Nurse Consultants supported by IDPH. The training series must be completed within one year of the date of hire.

Early ACCESS service coordinator

Early ACCESS service coordinators are required to possess at least one of the following:

- Bachelor's degree or higher
- Current license as a registered nurse (RN)

Additionally, the Early ACCESS service coordinator must complete required training requirements. See policy 609 for additional information.

Health education staff

Staff providing health education classes are required to possess at least one of the following:

- Bachelor's degree in health education, community health or public health
- Bachelor's degree in another health profession with experience in community education or secondary education
- Bachelor's degree with a health education endorsement
- Current license as a registered nurse.

Note: Under the maternal health (MH) program, health education services for a client must be provided by a registered nurse (RN). Oral health education under the MH program must be provided by a registered dental hygienist or a nurse trained by an I-Smile™ coordinator.

Psychosocial services staff

Persons providing psychosocial services are required to possess at least one of the following:

- Bachelor's degree in social work, sociology, counseling, psychology, family and community services, human development, health education, or individual and family studies
- Current license as a registered nurse (RN)

The Code of Iowa requires that all levels of trained social workers be licensable. Licensure of Bachelor Social Worker (LBSW) is voluntary. Licensure of Master Social Worker (LMSW) and Licensed Independent Social Worker (LISW) is mandatory.

Oral health staff

It is recommended that direct care oral health services are provided by an agency dental hygienist. However, based on an agency needs assessment and workforce availability, registered nurses, nurse practitioners and physician assistants employed or contracted by the agency may also provide direct oral health services.

Oral health services must be provided according to IDPH protocols and scope of practice regulations. Training for agency non-dental health professionals must be provided by the CH contract agency I-Smile™ coordinator. Upon request, the IDPH Oral Health Center will also provide training materials and technical assistance for local programs.

Additional information about required training and supervision is located in section 700 of this manual.

Direct service staff MCH contract agencies providing physical examinations for infants and children must employ or contract with licensed registered nurse practitioners, physician assistants with training in preventive health services for infants and children, or physicians.

MCH contract agencies providing direct client clinical services must have a formal agreement with a physician to serve as medical advisor to the program.

Orientation and continuing education All child and maternal health nursing personnel must complete orientation to MCH program requirements and demonstrate proficiency prior to providing clinical services.

MCH contract agencies must have a written policy for continuing education related to MCH for all personnel. An annual review of personnel competency and performance in the provision of family-centered client services is required.

Drug free work place In order to comply with the Drug Free Workplace Act of 1988 and 41 U.S. Code Annotated section 701, the MCH contract agency is required to report any conviction of an employee under a criminal drug statute for violations occurring on or off the MCH contract agency's premises while conducting official business. A report of a conviction must be made to IDPH within five working days after the conviction.



305 Health Insurance Portability and Accountability Act

Authority: Iowa Attorney General
Effective Date: January 19, 2012
Initial Revision
Replaces: 207 - October 2008

Determination The Iowa Department of Public Health published a statement regarding the effect of HIPAA privacy provisions on the release of protected health information to IDPH. The statement is located on the Internet at www.idph.state.ia.us/hipaa_statement.asp.

In part, the statement says “The Iowa Department of Public Health (IDPH), in conjunction with the Attorney General's Office, has completed a comprehensive review of its programs and has determined that neither the agency as a whole, nor any of its programs, are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, both the EPSDT Program and Enhanced Services for Maternal Health Program are actually a part of the Medicaid Program of the Iowa Department of Human Services, and as such, these programs will be business associates of the Iowa Department of Human Services and, therefore, subject to many HIPAA provisions.”

Business associate agreement The business associate agreement between IDPH and DHS is located in appendix A7 of this manual. The business agreement outlines responsibilities of IDPH and its contractors. Local contract agencies providing Medicaid services including maternal health services, EPSDT and oral health services are responsible for complying with the terms and conditions of the business associate agreement.

Disclosure of protected health information HIPAA recognizes that if there is a statute or administrative rule that requires a specific disclosure of protected health information, a covered entity must obey that law. Therefore, if there is a federal or state statute or administrative rule which requires or authorizes a covered entity to disclose protected health information to the IDPH, the covered entity should follow that requirement.

HIPAA also allows a covered entity to disclose protected health information to public health authorities for public health activities. This disclosure of public health information to IDPH is unaffected by HIPAA and should continue.

In some instances, IDPH is a health oversight agency as defined by HIPAA. As a result, HIPAA permits disclosure of protected health information to a health oversight agency for oversight activities authorized by law including audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for oversight.

Questions

For questions regarding other programs covered by this MCH Administrative Manual or other Iowa Department of Public Health programs, please refer to the IDPH website regarding HIPAA at www.idph.state.ia.us/hipaa_statement.asp



306 Protecting Client Records

Authority: not applicable

Effective Date: October 16, 2012

Initial **Revision**

Replaces: 306 – January 2012

Confidential records

All paper and electronic client records that include information on the identity, assessment, diagnosis, prognosis and services provided to specific individuals or families are considered confidential information and must be protected. MCH contract agencies must have policies and procedures that safeguard the confidentiality of records.

Handling of records

Client records, both paper and electronic, may only be accessed within the offices and clinics of the MCH contract agency. MCH contract agencies are required to assure that employees are allowed access to records only for the performance of their duties related to the contract and in accordance with the policies and procedures of the MCH contract agency. All MCH contract agencies are required to provide offices and equipment that secure the confidential information.

Storage of records

Best practice is to store confidential records in locked file cabinets. Confidential records may be stored on an open shelf *only if* the room and building have the capability of being locked.

Transport of records to MCH offices/clinics

When transporting confidential records between MCH offices or clinics, best practice is to secure them in the trunk or rear of the vehicle. Assure they are shielded from view from the outside of the vehicle.

Data entry

MCH contract agencies and their subcontractors are prohibited from accessing electronic or paper records or performing data entry from a location other than offices or clinics of the MCH contract agency. For example, accessing records or performing data entry from a public computer or a privately-owned home computer is prohibited.

If an MCH contract agency has staff utilizing field offices or has extenuating circumstances, the agency must request an exception to this policy to allow staff to access IDPH data systems from an alternate location. The exception to policy must be approved prior to staff accessing the data systems from the location outside of the offices or clinics of the MCH contract agency. Requests for exception to this policy must be made to the chief of the Bureau of Family Health and should include the following:

- Justification as to why access is needed at the alternate location
- Location where the staff will access the data systems
- Staff person(s) that will access IDPH data systems outside of the offices or clinics of the MCH contract agency
- Which IDPH applications will be accessed by the staff person(s)
- Assurance that the agency-owned equipment will be used for the sole purpose of conducting business for the MCH contract agency
- Assurance that the staff will utilize only agency-owned equipment for conducting business on behalf of the MCH contract agency
- Assurance that only the agency staff will have access to the agency-owned computer
- Assurance that the agency-owned computer will remain secured in the possession of agency staff at all times
- Assurance that the equipment will be connected to the Internet through a secure connection
- Assurance that the equipment has full disk encryption
- Timeframe requested for the exception to policy, not to exceed the length of the MCH contract project period

MCH contract agencies using wireless connections must ensure that the wireless connections are secure, requiring a password to connect to the wireless network. MCH contract agencies may not access IDPH applications on an open access wireless network (e.g., Wi-Fi connection at local coffee shops or staff members' homes).

**CAReS
security
agreements**

Personnel of MCH contract agencies and their subcontractors using CAReS are required to sign an IDPH security agreement prior to accessing the system and the agreements must be updated annually.

Under no circumstances are individual passwords to be shared. Security agreement violations will result in disciplinary action.

See policy 309 for additional information about record security.



307 Consent for Services

Authority: Iowa Administrative Code 641 IAC 76.5(1)

Effective Date: January 19, 2012

Initial Revision

Replaces: 305 - October 2008

Consent for services

All clients presenting for MCH services will sign a consent for services that includes both of the following:

- Permission for the bureau chiefs of the Bureau of Family Health and Oral and Health Delivery Systems and/or designees to have access to medical records
- Notification that the records are the property of the Iowa Department of Public Health

A signed consent for services must be obtained from each client. Consent should be obtained prior to receiving direct care services. A copy of the consent will be maintained in the client record.

Clients who do not present for services

Not all clients appear in person for services. For example, clients who receive informing and care coordination services are often contacted by phone. These clients are being served under contract between the Iowa Department of Human Services (Iowa Medicaid Enterprise) and the Iowa Department of Public Health. Authorization for receipt of these services is included in the client's application for Title XIX services.

Consent forms

Sample maternal health and child health consent forms are found in on the MCH Project Management Tools website at www.idph.state.ia.us/hpcdp/mch_costing.asp and in appendices A16 and A17 of this manual. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.



308 Release of Information

Authority: 42 CFR; Iowa Administrative Code 641 IAC 140.1; contract general conditions

Effective Date: January 19, 2012

Initial Revision

Replaces: 305 and 314 - October 2008

Release of confidential information

All paper and electronic client records that include information on the identity, assessment, diagnosis, prognosis and services provided to specific individuals or families are considered confidential information. Confidential information may not be shared without a *signed authorization for release*.

Such records will be disclosed only under the circumstances expressly authorized under state or federal confidentiality laws, rules or regulations. MCH contract agencies must have policies and procedures that safeguard the confidentiality of records and may be liable civilly, contractually or criminally for unauthorized release of such information.

The authorized sharing of confidential information can benefit the client or program for purposes such as case management, referral, program evaluation or sharing of demographic information.

Content of forms

A signed authorization for release of information must be obtained from each client prior to the release of records. A release may be obtained as part of the enrollment process. A copy of the release will be maintained in the client record.

All consents for release of information must be informed. Release of information forms must specify the following details:

- Information that will be exchanged
- Who or what agencies will have access to the information
- The way in which the information will be used
- If the information will be kept confidential

Specific authorization must be obtained prior to releasing substance abuse information, mental health information and HIV/AIDS

information.

Signatures

Release of information forms are signed by the client or parent/guardian.

Information related to diagnosis and treatment of sexually transmitted disease, HIV testing, diagnosis and treatment of substance abuse and family planning can be released only by the individual receiving services, even if the client is a minor. For these services, authorization signed by the individual receiving services must be obtained to release information to anyone, including a parent or guardian.

Other health information may be released to the parent or guardian of a minor under current Iowa code and practice.

Sample form

A sample form for release of information is found in appendix A18 and on the MCH Project Management Tools website at www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.

The form facilitates multiple releases of information between specific agencies for a one-year timeframe. Before utilizing the form, it is recommended that the attorney(s) for the MCH contract agency and local providers agree to its use.

Review of release policies

MCH contract agencies and their subcontractors are required to review their confidentiality policies annually. MCH contract agencies with questions regarding their release of confidential information policies are encouraged to contact their attorney.

Laws governing the sharing of information

Laws from a variety of sources govern information sharing. Key authorities include, but are not limited to:

- Iowa Code and Iowa Administrative Code
- Computer Matching and Privacy Act 1988
- Privacy Act of 1974
- Freedom of Information Act
- Maternal and Child Health Block Grant law
- WIC law
- Medicaid laws
- Food Stamp Act of 1964
- Health Insurance Portability and Accountability Act (HIPAA) and

amendments

- Family Educational Rights and Privacy Act (FERPA)
 - Social Security law
 - Parental Notification of Intent To Terminate A Pregnancy Through Abortion code
 - Public Health Service law
 - U.S. Department of Health and Human Services' (DHHS) Standards of Privacy, 45 CFR
-

Reporting that does not require release authorization

Information or data that is reported in aggregate, statistical summary or other form that does not identify specific individuals may be disclosed without a signed authorization for release of information.

As established by Iowa Code, information on reportable diseases is to be sent to the Iowa Department of Public Health, Division of Acute Disease Prevention and Emergency Response. All cases of suspected child abuse and neglect are to be reported to the local office of the Iowa Department of Human Services. Such reports are required by law and do not require authorization for release of information.

See Policy 305 of this manual for additional information regarding HIPAA.



309 Electronic Requirements

Authority: not applicable
Effective Date: October 16, 2012
Initial **Revision**
Replaces: 309 – January 2012

Requirements Electronic requirements may be updated as technology needs of the MCH program change and as technology upgrades become available. Current requirements are referenced below.

Computers MCH contract agencies are required to have an IBM compatible computer with Pentium (or equivalent) processor, a minimum of 1 gigabyte (GB) of RAM and 80 GB total hard drive disk space.

Software Minimum required software for each MCH contract agency includes:

- Microsoft Windows XP, service pack 3 and current updates
- Microsoft Office 2003 Standard or more recent
- Microsoft Access 2003 (MH program for WHIS)
 - Recommended: MS Access 2007 or higher
- Internet Explorer 7.0 or higher
 - Recommended: Internet Explorer 8.0 or higher
- Adobe Reader 9.0 or higher
- Microsoft.Net Framework 4.0 (CH program for CAREs)

Internet access All MCH contract agencies must maintain high-speed Internet access of 1.5 megabits/second (Mbps), unless not available in their service delivery area. It is recommended that MCH contract agencies maintain Internet connection speeds as fast as can be afforded as available in the local service area.

For Child Health contract agencies: If clinics will be using computers for other applications that require Internet connectivity, or if network connectivity is shared over a Wireless Access Network (WAN) for logins to a central server for other purposes, the above recommendations will need to be increased to allow for other traffic.

Program Administration

Connectivity to CARES is subject to competition with other network resources and requires adequate bandwidth for reliable operation.

MCH contract agencies may connect to the Internet and IDPH applications through wired or wireless connections. Each connection must be secure, requiring a password to connect to the network.

Email

MCH contract agencies are required to maintain individual email addresses, with the capacity to send and receive electronic communications (email and attachments), for all personnel as listed on the contact information forms.

Security

MCH contract agencies are required to use full disk encryption software to protect against unauthorized users.

In addition, all MCH contract agency computers must have software to protect them from viruses and spyware. Recommended anti-virus software includes:

- Norton products
- McAfee products

MCH contract agencies must notify IDPH prior to upgrading or transferring computers.

IDPH applications will only be accessed within the offices and clinics of the MCH contract agency. Agencies using wireless connections must ensure that the connections are secure and require a password. MCH contract agencies may not access IDPH applications on an open access wireless network (e.g., Wi-Fi connection at local coffee shops or staff members' homes). See policy 306 for additional information about access to IDPH applications from alternate locations.

Back-up of WHIS database

One WHIS database file requires backup by the local MH agency. This file is entitled DPHDAT.MDB. At a minimum, daily backups should be performed. Best practice would be to define three sets of backups; daily, weekly and monthly. The daily backups would be rotated on a daily basis with one graduating to weekly status each week. The weekly backups would be rotated on a weekly basis with one graduating to monthly status each month.

Ideally, weekly backups should be stored in a location separate from the original site (in a different building) for disaster recovery purposes. If the original site were damaged, this would minimize any loss of data.



310 Minor Consent Laws

Authority: See authority references in text
Effective Date: January 19, 2012
Initial Revision
Replaces: 307 – October 2009

Iowa code

Iowa law contains several provisions which govern a minor's ability to consent to health care and services. The text of many of these laws is contained in this section. In addition, certain specific hyperlinks to additional provisions of law have been inserted into the electronic version of this manual. Please note that website addresses are subject to change without notice.

Age of majority

Iowa law generally provides that a person under the age of 18 years is a minor. However, persons who are married prior to the age of 18 years and persons who are incarcerated as adults are deemed to have attained the age of majority.

The text of the law provides as follows:

The period of minority extends to the age of 18 years, but all minors attain their majority by marriage. A person who is less than 18 years old, but who is tried, convicted and sentenced as an adult and committed to the custody of the director of the department of corrections shall be deemed to have attained the age of majority for purposes of making decisions and giving consent to medical care, related services and treatment during the period of the person's incarceration.

Iowa Code § 599.1. See also Iowa Code §§ 135L.1(7), 239B.1(9), 600A.2(12), 728.1(4).

Consent generally required from parent or guardian

The general common law rule is that in order to provide medical treatment or services to a minor, a health care provider must first obtain the consent of the minor's parent or guardian. Courts have recognized exceptions to the general rule of parental consent. In addition, the Iowa legislature has enacted several provisions in which minors are deemed to be emancipated and able to independently consent to medical care. The purpose behind these statutes is to encourage minors to receive medical care they might not otherwise receive if they had to obtain consent from a parent or guardian. Every state legislature, including Iowa's, has enacted statutory exceptions to override the common law rule and give minors the legal authority to consent to some form of medical care for certain diseases and conditions.

Specific type of service and care for which minors can consent

Consent for Contraceptive Services

In Iowa minors are able to consent to contraceptive services. A health care provider is not required to obtain consent from a parent or guardian prior to providing contraceptive services to a minor.

The relevant portion of the text of the law provides as follows:

A person may apply for...contraceptive services...directly to a licensed physician and surgeon, an osteopathic physician and surgeon, or a family planning clinic.The minor shall give written consent to these procedures and to receive the services, screening, or treatment. Such consent is not subject to later disaffirmance by reason of minority.

Iowa Code § 141A.7(3). See also *Carey v. Population Services, International*, 431 U.S. 678 (1977); Title X Family Planning Program.

Consent for Care for Sexually Transmitted Diseases

Iowa law authorizes a minor to provide consent for medical services related to the prevention, diagnosis or treatment of a sexually transmitted disease. Minors are able to provide consent for prevention services such as the hepatitis B vaccine, and for treatment for STD's

including chlamydia, gonorrhea, hepatitis B, hepatitis C, human papillomavirus and syphilis. A health care provider is not required to obtain consent from a parent or guardian prior to providing these services to a minor.

The text of the law provides as follows:

A minor shall have the legal capacity to act and give consent to provision of medical care or services to the minor for the prevention, diagnosis or treatment of a sexually transmitted disease or infection by a hospital, clinic or health care provider. Such medical care or services shall be provided by or under the supervision of a physician licensed to practice medicine and surgery or osteopathic medicine and surgery, a physician assistant or an advanced registered nurse practitioner. Consent shall not be subject to later disaffirmance by reason of such minority. The consent of another person, including but not limited to the consent of a spouse, parent, custodian or guardian, shall not be necessary.

Iowa Code § 139A.35.

HIV/AIDS Care

Iowa law authorizes a minor to give consent to receive services, screening, testing and treatment for HIV/AIDS, and provides that the consent of a parent or guardian is not required to provide these services. However, the law does require that a minor must be informed prior to testing that if the test result is positive the minor's legal guardian shall be informed by the testing facility.

The text of the law provides as follows:

Notwithstanding any other provision of law, however, a minor shall be informed prior to testing that, upon confirmation according to prevailing medical technology of a positive HIV-related test result, the minor's legal guardian is required to be informed by the testing facility. Testing facilities where minors are tested shall have available a program to assist minors and legal guardians with the notification process which emphasizes the need for family support and assists in making available the resources necessary to accomplish that goal. However, a testing facility which is precluded by federal statute, regulation, or centers for disease control and prevention

guidelines from informing the legal guardian is exempt from the notification requirement. The minor shall give written consent to these procedures and to receive the services, screening or treatment. Such consent is not subject to later disaffirmance by reason of minority.

Iowa Code § 141A.7(3).

Drug and Alcohol Treatment

Iowa law authorizes a minor to consent for substance abuse treatment. A substance abuse facility or a physician or physician's designee providing substance abuse treatment or rehabilitative services is not required to obtain consent from a parent or guardian prior to providing these services to a minor.

The text of the law provides as follows:

A substance abuser or chronic substance abuser may apply for voluntary treatment or rehabilitation services directly to a facility or to a licensed physician and surgeon or osteopathic physician and surgeon. If the proposed patient is a minor or an incompetent person, a parent, a legal guardian or other legal representative may make the application. The licensed physician and surgeon or osteopathic physician and surgeon or any employee or person acting under the direction or supervision of the physician and surgeon or osteopathic physician and surgeon, or the facility shall not report or disclose the name of the person or the fact that treatment was requested or has been undertaken to any law enforcement officer or law enforcement agency; nor shall such information be admissible as evidence in any court, grand jury, or administrative proceeding unless authorized by the person seeking treatment. If the person seeking such treatment or rehabilitation is a minor who has personally made application for treatment, the fact that the minor sought treatment or rehabilitation or is receiving treatment or rehabilitation services shall not be reported or disclosed to the parents or legal guardian of such minor without the minor's consent, and the minor may give legal consent to receive such treatment and rehabilitation.

Iowa Code § 125.33(1).

Other Specific Services:

Inpatient Mental Health Services (Iowa Code § 229.2(1))

<http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=iowaCode&ga=82&input=229.2>

Decision Making Assistance and Parental Notification of Intent to Terminate a Pregnancy Through Abortion (Iowa Code § 135L.2)

<http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=iowaCode&ga=82&input=135L.2>

Pregnant minors

Iowa law does not expressly address whether minors can receive prenatal care services without consent from a parent or guardian. However, federal and state common law and statutes do likely authorize a minor to consent to these services without parental consent in the majority of health care settings. Providers with questions about this area of law are encouraged to contact their own legal counsel for guidance.



311 Recognition of Child Abuse and Neglect

Authority: See authority references in text

Effective Date: January 19, 2012

Initial Revision

Replaces: 309 – October 2008

Child abuse under Iowa law

The Iowa Department of Human Services has the legal authority to conduct an assessment of child abuse when it is alleged that:

- The victim is a child
- The child is subjected to one or more of the eight categories of child abuse defined in Iowa Code section 232.68:
 - Physical abuse
 - Mental injury
 - Sexual abuse
 - Child prostitution
 - Presence of illegal drugs
 - Denial of critical care
 - Manufacturing or possession of a dangerous substances (defined in Iowa Code 232.2)
 - Bestiality in the presence of a child
- The abuse is the result of the acts or omissions of the person responsible for the care of the child

Physical abuse

"Physical abuse" is defined as any non-accidental physical injury, or injury which is at variance with the history given of it, suffered by a child as the result of the acts or omissions of a person responsible for the care of the child.

Common indicators could include unusual or unexplained burns, bruises or fractures. Health services personnel should be especially alert to cases of child abuse where inconsistent histories are presented. Inconsistent histories can take the form of an explanation that does not fit the degree or type of injury to the child or where the story or explanation of the injury changes over time.

Some indicators of child abuse are not visible on the child's body. Many times there are no physical indicators of abuse. A child's

behavior can change as a result of abuse. Health services personnel need to be alert to possible behavioral indicators of abuse and if they believe those to be present, they are required to make a report.

Behavioral indicators include behaviors such as:

- Extreme aggression
- Withdrawal
- Seductive behaviors
- Being uncomfortable with physical contact or closeness

Mental injury

"Mental injury" is defined as any mental injury to a child's intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child's ability to function within the child's normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional as defined in Iowa Code section 622.10.

Examples of mental injury may include:

- Ignoring the child and failing to provide necessary stimulation, responsiveness and validation of the child's worth in normal family routine
- Rejecting the child's value, needs and request for adult validation and nurturance
- Isolating the child from the family and community; denying the child normal human contact
- Terrorizing the child with continual verbal assaults, creating a climate of fear, hostility and anxiety, thus preventing the child from gaining feelings of safety and security
- Corrupting the child by encouraging and reinforcing destructive, antisocial behavior until the child is so impaired in socio-emotional development that interaction in normal social environments is not possible
- Verbally assaulting the child with constant, excessive name-calling, harsh threats and sarcastic put downs that continually "beat down" the child's self-esteem with humiliation
- Over-pressuring the child with subtle but consistent pressure to grow up fast and to achieve too early in the areas of academics, physical or motor skills, or social interaction, which leaves the child feeling that he or she is never quite good enough

Sexual abuse

"Sexual abuse" is defined as the commission of a sexual offense with or to a child pursuant to Iowa Code chapter 709, Iowa Code section

726.2, or Iowa Code section 728.12, subsection 1, as a result of the acts or omissions of the person responsible for the care of the child.

Notwithstanding Iowa Code section 702.5, the commission of a sexual offense under this paragraph includes any sexual offense referred to in this paragraph with or to a person under the age of 18 years.

There are several sub-categories of sexual abuse:

- First degree sexual abuse: Sexual abuse in the first degree is a class "A" felony. A person commits sexual abuse in the first degree when in the course of committing sexual abuse the person causes another serious injury.
- Second degree sexual abuse: Sexual abuse in the second degree is a class "B" felony. A person commits sexual abuse in the second degree when the person commits sexual abuse under any of the following circumstances:
 1. During the commission of sexual abuse the person displays in a threatening manner a dangerous weapon, or uses or threatens to use force creating a substantial risk of death or serious injury to any person
 2. The other person is under the age of twelve
 3. The person is aided or abetted by one or more persons and the sex act is committed by force or against the will of the other person against whom the sex act is committed
- Third degree sexual abuse: Sexual abuse in the third degree is a class "C" felony. A person commits sexual abuse in the third degree when the person performs a sex act under any of the following circumstances:
 1. The act is done by force or against the will of the other person, whether or not the other person is the person's spouse or is cohabiting with the person.
 2. The act is between persons who are not at the time cohabiting as husband and wife and if any of the following are true:
 - a. The other person is suffering from a mental defect or incapacity which precludes giving consent.
 - b. The other person is twelve or thirteen years of age.
 - c. The other person is fourteen or fifteen years of age and any of the following are true:
 - (1) The person is a member of the same household as the other person.
 - (2) The person is related to the other person by blood or affinity to the fourth degree.
 - (3) The person is in a position of authority over the other person and uses that authority to coerce the other

- person to submit.
- (4) The person is four or more years older than the other person.
 3. The act is performed while the other person is under the influence of a controlled substance, which may include but is not limited to flunitrazepam, and all of the following are true:
 - a. The controlled substance, which may include but is not limited to flunitrazepam, prevents the other person from consenting to the act.
 - b. The person performing the act knows or reasonably should have known that the other person was under the influence of the controlled substance, which may include but is not limited to flunitrazepam.
 4. The act is performed while the other person is mentally incapacitated, physically incapacitated or physically helpless.

Additional sub-categories of sexual abuse include:

- Detention in a brothel
- Lascivious acts with a child
- Indecent exposure
- Assault with intent to commit sexual abuse
- Indecent contact with a child
- Lascivious conduct with a minor Incest: A person, except a child as defined in section 702.5, who performs a sex act with another whom the person knows to be related to the person, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece or nephew, commits incest. Incest is a class "D" felony.
- Sexual exploitation by a counselor or therapist
- Sexual exploitation of a minor
- Sexual misconduct with offenders and juveniles

Behavioral indicators of sexual abuse could include things such as excessive knowledge of sexual matters beyond their normal developmental age or seductiveness. Physical indicators of sexual abuse could include things such as bruised or bleeding genitalia, venereal disease or even pregnancy.

There are specific physical examination procedures used in child abuse. For instance, in the evaluation of sexual abuse, the colposcope provides for a taped copy of that examination. That copy alleviates the need then for the child to be subjected to further examinations.

Denial of critical care

What many people think of as an issue of "neglect" is covered under the child abuse category of "denial of critical care."

"Denial of critical care" is defined as the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so.

A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child. However, this does not preclude a court from ordering that medical service be provided to the child where the child's health requires it.

Denial of critical care includes the following eight sub-categories:

- Failure to provide adequate food and nutrition to such an extent that there is danger of the child suffering injury or death.
- Failure to provide adequate shelter to such an extent that there is danger of the child suffering injury or death
- Failure to provide adequate clothing to such an extent that there is danger of the child suffering injury or death
- Failure to provide adequate health care to such an extent that there is danger of the child suffering serious injury or death
- Failure to provide the mental health care necessary to adequately treat an observable and substantial impairment in the child's ability to function
- Gross failure to meet the emotional needs of the child necessary for normal development evidenced by the presence of an observable and substantial impairment in the child's ability to function within the normal range of performance and behavior
- Failure to provide proper supervision of a child which a reasonable and prudent person would exercise under similar facts and circumstances, to such an extent that there is danger of the child suffering injury or death

Note: This definition includes cruel and undue confinement of a child and the dangerous operation of a motor vehicle when the person responsible for the care of the child is driving recklessly or driving while intoxicated with the child in the vehicle.

The Iowa Department of Human Services receives many inquiries each year regarding when a child can be left home alone safely. Iowa law does not define an age that is appropriate for a child to be left alone. Each situation is unique. Examples of questions to help determine whether there are safety concerns for the child include:

- Does the child have any physical disabilities?
 - Could the child get out of the house in an emergency?
 - Does the child have a phone and know how to use it?
 - Does the child know how to reach the caretaker?
 - How long will the child be left home alone?
 - Is the child afraid to be left home alone?
 - Does the child know how to respond to an emergency such as fire or injury?
- Failure to respond to the infant's life-threatening conditions by failing to provide treatment which in the treating physician's judgment will be most likely to be effective in ameliorating or correcting all conditions. This subcategory or the denial of critical care abuse type is also known as withholding of medically indicated treatment. The type of treatments included is appropriate nutrition, hydration and medication. The term does not include the failure to provide treatment other than appropriate nutrition, hydration and medication to an infant when in the treating physician's medical judgment, any of the following circumstances apply:
 - The infant is chronically and irreversibly comatose.
 - The provision of treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant.
 - The provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.

Additional information may be found on the Iowa Department of Human Services website under www.dhs.iowa.gov/Consumers/Safety_and_Protection/Abuse_Reporting/ChildAbuse.html



312 Mandatory Reporting of Child Abuse and Neglect

Authority: Iowa Administrative Code 441 IAC 175; Iowa Code 232.68

Effective Date: January 19, 2012

Initial Revision

Replaces: 308 – October 2008

Child abuse and neglect

Child abuse is a term covering ten forms of child maltreatment as defined by Iowa Code 232.68. Child abuse in Iowa includes:

- Physical abuse
- Mental injury
- Sexual abuse
- Denial of critical care
- Child prostitution
- Presence of illegal drugs
- Manufacturing or possession of a dangerous substance
- Bestiality in the presence of a child
- Knowingly allowing a registered sex offender access to a child
- Knowingly allowing a child to access obscenity

Each MCH contract agency is required to have a policy regarding child abuse reporting. The policy must be consistent with Iowa Code 232.68.

Mandatory reporting

Since the late 1960s, every state has enacted a child abuse reporting law. In Iowa, mandatory reporters are designated persons who are required to report suspected cases of child abuse. A permissive reporter is any person who suspects child abuse. Mandatory reporters may report as permissive reporters when they suspect abuse of a child outside the scope of their professions.

The following are links to Iowa code dealing with child abuse and neglect reporting related to child health service providers. It is not intended to be a complete rendering of the law. MCH contract agencies are responsible for contacting the local office of the Iowa Department of Human Services for guidance and interpretation of the law.

Training for mandatory & permissive reporters <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=232.69>

Reporting procedure <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=232.70>

Immunity from liability <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=232.73>

Sanctions <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=232.75>

Photographs, x-rays and medically relevant tests <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=232.77>

Custody without court order <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=232.79>

Central registry <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=lowaCode&ga=82&input=235A.12>

Resources

- *Child Abuse: A Guide for Mandatory Reporters, July 1, 2011.* Can be found on the Iowa Department of Human Services website at www.dhs.state.ia.us/policyanalysis/policymanualpages/Manual_Documents/Master/comm164.pdf
- Child Abuse Report Hotline: 1-800-362-2178



313 OSHA Regulations

Authority: See authority references in text

Effective Date: January 19, 2012

Initial Revision

Replaces: 310 - October 2008

Assurance

The Occupational Safety and Health Act of 1970 was passed to prevent workers from being killed or seriously harmed at work. The law requires employers to provide their employees with working conditions that are free of known dangers. The act created the Occupational Safety and health Administration (OSHA) that sets and enforces protective workplace safety and health standards. OSHA also provides information, training and assistance to workers and employers. OSHA regulations are found at www.osha.gov.

MCH contract agencies are responsible for assuring their operation is in compliance with all applicable OSHA requirements. If you have questions regarding requirements or implementation of the OSHA regulations, please contact:

Iowa Division of Labor Services
1000 East Grand Avenue
Des Moines, IA 50319-0209
(515) 281-3606



314 OSHA Bloodborne Pathogen Standard

Authority: Title 29 CFR, Part 1910.1030

Effective Date: January 19, 2012

Initial Revision

Replaces: 311 – October 2008

Standard

Bloodborne pathogens are infectious microorganisms present in blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV), the virus that causes AIDS. Workers exposed to bloodborne pathogens are at risk for serious or life-threatening illnesses.

Universal precautions will be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids will be considered potentially infectious materials.

The Occupational Safety and Health Administration (OSHA) bloodborne pathogen standard prescribes safeguards to protect workers against the health hazards related to exposure to bloodborne pathogens. It identifies how to determine who has occupational exposure and how to reduce the risk of workplace exposure.

The standard requires the employer to develop a written exposure control plan. At a minimum the plan must include:

- Exposure determination
- Procedures for evaluating the circumstances surrounding an exposure incident
- Schedule and method for implementing sections of the standard covering methods of compliance, hepatitis B vaccination and post-exposure follow-up, communication of hazards to employees and record-keeping

The full standard relating to occupational exposure to bloodborne pathogens can be found on the OSHA website at

www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

**Additional
information**

Additional information related to vaccination for hepatitis B virus and management of exposure to blood and infectious body fluids through the skin can be found at www.cdc.gov/MMWR/preview/MMWRhtml/00001450.htm or in the *Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers*, MMWR, DHHS, Public Health Service, Centers For Disease Control, National Institute for Occupational Safety and Health Atlanta Georgia, June 23, 1989/Vol. 38/No S-6 page 452.



315 Client Eligibility for MCH Services

Authority: IAC 641-76.6 (135) Social Security Act Title V Sec 506 [42 USC 706]
Effective Date: January 19, 2012
Initial Revision
Replaces: 312—October 2009

Eligibility

All women of childbearing age and children under 22 years of age who are residents of Iowa are eligible for Maternal and Child Health (MCH) services. Title V provides financial assistance for women and children who qualify based on their family's income.

Income guidelines for assistance are the same as those established for the state's Title XXI (*hawk-i*) program (based upon Federal Poverty Guidelines). Federal Poverty Guidelines are published annually by the U.S. Department of Health and Human Services (DHHS) and are posted on the website at www.aspe.hhs.gov/poverty/index.shtml. MCH eligibility guidelines are adjusted following any change in DHHS guidelines.

Income eligibility for financial assistance

Eligibility for the Maternal and Child Health program is based upon either of the following:

- Income information provided by the individual and/or family (self-declared)
- Proof of Title XIX, Title XXI or WIC eligibility which automatically serves in lieu of an application

For purposes of initial and continued eligibility, all earned and unearned income of family members is used in determining the individual and/or family's gross income.

Family is defined as a group of two or more persons related by birth, marriage or adoption or residing together and which function as one economic unit. Determine household size by considering the pregnant woman, the unborn child or children, the father of the unborn child (if he is in the home) and any siblings of the unborn child residing with the pregnant woman.

Income is calculated as follows:

- Annual income is estimated based on the individual and/or family's

income for the past three months, unless the individual and/or family's income will be changing or has changed.

- In the case of self-employed families, the past year's income tax return (adjusted gross) is used in estimating annual income unless a change has occurred.
 - Terminated income is not considered.
-

Determining fees for maternal and child health services

Eligibility for Title XIX (Medicaid) and Title XXI (*hawk-i*):

Individuals and/or families are screened for eligibility for Title XIX, Title XXI and WIC. If an individual/family's income is within the eligibility guidelines for either Title XIX or Title XXI, the individual and/or family should be referred to the Iowa Department of Human Services or other enrollment source to apply for Medicaid or *hawk-i* coverage. Infants, children and pregnant women will be considered for Title XIX presumptive eligibility.

- An individual and/or family whose income is below the poverty level established by Title XXI receive MCH services at no charge.
- An individual and/or family whose income is above the poverty level established by Title XXI and below 300 percent of federal poverty guidelines qualify for MCH services on a sliding fee scale.
- An individual and/or family whose income is at or above 300 percent of the poverty level qualify for MCH services at full fee.

Eligibility determinations must be done at least once annually. Should the individual and/or family's circumstances change in a manner that affects third-party coverage or Title XIX and/or Title XXI eligibility, eligibility determinations will be completed more frequently.

Residency

An individual and/or family must be currently residing in Iowa.

Pregnancy

An individual applying for the maternal health program will have verification of pregnancy by any of the following:

- An independent health provider
 - The maternal health contract agency
 - A family planning (Title X) provider
 - Through use of a positive home pregnancy test.
-



316 Applying for Medicaid or *hawk-i*

Authority: Iowa Administrative Code 641 IAC 76.7 (135)

Effective Date: January 19, 2012

Initial Revision

Replaces: 313 - October 2009

Application forms

A person desiring direct maternal or child health services or the parent or guardian of a minor desiring such care may apply to an MCH contract agency using the Health Services Application (English: form 470-2927. Spanish: form 470-2927SP) or the *hawk-i* application (available in both English and Spanish).

Health services application

The Health Services Application can be used as a common application form for Child Health Services, Maternal Health Services, Presumptive Medicaid Eligibility for Pregnant Women, Medicaid (Title XIX) and WIC. The Health Services Application form is available online at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/470-2927.pdf and can be printed to send to those entities that provide the various services.

Note: If a client is currently enrolled in *hawk-i* or Medicaid, this application is not required.

hawk-i application

The *hawk-i* application is used to apply for health care coverage under Title XXI for uninsured children up to 19 years of age. Applications are screened for Medicaid eligibility by the third party administrator and are then forwarded to the Iowa Department of Human Services if the child appears to be eligible for that program. A copy of this application may serve as application for MCH services.

The *hawk-i* application will be offered to uninsured infants, children and postpartum teenagers less than 19 years of age. Clients may need assistance in completing the application. Proof of family income is required with the application.

hawk-i outreach materials, application forms and answers to questions

regarding enrollment may be obtained by calling 1-800-257-8563. Information on **hawk-i** can also be accessed on the Internet at www.hawk-i.org. An electronic application is also available on this website.

Additional information about **hawk-i** is available in policy 613 of this manual.



317 Admissions

Authority: Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V Sec 506 [42 USC 706]
Effective Date: January 19, 2012
Initial Revision
Replaces: 315—October 2008

Admission to maternal health services

The purpose of an admission into the maternal health program is to provide prenatal care that promotes optimal birth outcomes and family-centered health care that contributes to the health of the mother and infant and the well-being of the family. Clients requesting maternal health services are asked to sign a consent for services as discussed in policy 307 of this manual.

To meet the requirements of an admission for the maternal health program, contact must be in person (face-to-face) or by telephone. A message left electronically does not meet the requirements for an admission.

Any client admitted to the maternal health program must be entered in the Women's Health Information System (WHIS).

Admission to child health services

The purpose of an admission into the child health program is to assist the family to access primary and preventive health care for their child. Children (birth to age 22); parents of the child; or a family member or guardian (with decision-making responsibility on behalf of the child) requesting services are asked to sign a consent for services as discussed in policy 307 of this manual.

A child may be admitted as a dental-only client if the MCH contract agency has assured that the child's medical needs/services are being met elsewhere.

To meet the requirements of an admission for the child health program, contact must be in person (face-to-face) or by telephone. A message left electronically does not meet the requirements for an admission.

Any client admitted to the child health program must be entered in the Child Health Reporting System (CAREs).



318 Civil Rights

Authority: See authority references in Text
Effective Date: January 19, 2012
Initial Revision
Replaces: 316 - October 2008

Compliance

It is the Iowa Department of Public Health's policy to comply with the Iowa Civil Rights Act of 1965. The Act prohibits discrimination in the areas of employment, housing, credit, public accommodations and education.

Discrimination or different treatment is illegal if based on race, color, creed, national origin, religion, sex, sexual orientation, gender identity, pregnancy, physical disability, mental disability, retaliation (because of filing a previous discrimination complaint, participating in an investigation of a discrimination complaint, or having opposed discriminatory conduct), age (in employment and credit), familial status (in housing and credit), or marital status (in credit).

The MCH contract agency must comply with all relevant provisions of the Act, Title VI of the Civil Rights Act of 1964 (PL 88-352), Part 80 of Title 45, Code of Regulations, Section 504 of Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 as amended, the Iowa Civil Rights Act of 1965 as amended, Equal Employment Opportunity Act of 1973, the Age Discrimination Act of 1968 and 1975, and 7 CFR Part 15.

Additional information

For information on civil rights and discrimination, including educational materials, videotapes or speakers for workshops, contact:

Iowa Civil Rights Commission
Grimes State Office Building
400 E. 14th Street, Room 201
Des Moines, IA 50319-0201
Phone 515-281-4121 or Toll Free 1-800-457-4416
Fax 515-242-5840

www.state.ia.us/government/crc/



319 Technical Assistance

Authority: Iowa Administrative Code 641 IAC 76 (135)

Effective Date: January 19, 2012

Initial Revision

Replaces: 317 - October 2008

Technical assistance

Consultants from the Bureau of Family Health and Oral and Health Delivery Systems are available to provide technical assistance (TA) and consultation to MCH contract agencies. Technical assistance can guide agencies in the following areas:

- Defining the program's purpose
- Interpreting program requirements
- Strengthening the ability of the MCH contract agency to fulfill the goals of the MCH program
- Quality assurance and quality improvement
- Community needs assessment and health improvement planning

Possible reasons for seeking TA

There are many reasons that an MCH contract agency may choose to seek technical assistance. These may include:

- Asking for clarification or explanation about a specific topic
- Best practices from other MCH contract agencies
- Identifying resources
- Asking for independent and/or objective perspective
- Clarifying the program's purpose, goals and requirements
- Asking for advice about program implementation that is either working effectively or needs a new direction
- Blending and braiding of resources

What TA can accomplish

There are many potential benefits of seeking technical assistance such as:

- Identifying, exploring, defining or prioritizing issues
- Resolving problems through analysis of issues or implementing processes
- Introducing or facilitating change
- Sharing expertise or knowledge with the MCH contract agency and IDPH staff

**How to
request TA**

The project director of the MCH contract agency may request technical assistance by contacting the consultant assigned to the agency. Through discussion with the consultant the following information regarding the TA request will be identified:

- The nature of the request
 - A detailed description of the issues to be discussed including specific questions to be addressed, history or background of events that preceded the request and previous TA on the topic
 - Manner in which the TA is desired (e.g. conference call, site visit, webinar)
 - Proposed timeline
 - Suggested individuals from IDPH to be involved
 - MCH contract agency personnel or other individuals to be involved
-



320 Community Health Needs Assessment and Health Improvement Plan

Authority: Iowa Administrative Code 641 IAC 76.5(1)

Effective Date: January 19, 2012

Initial Revision

Replaces: 318 – October 2008

Definition

The Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP) process is a core function of public health that encourages communities across Iowa to assure the health of their citizens through assessment and planning. Each local board of health assesses leading health indicators, prioritizes health needs and creates a health improvement plan to address their critical health needs. The process encourages ongoing assessment, planning and evaluation.

MCH participation

MCH contract agencies will support the MCH component for the CHNA & HIP process in all the counties in which they intend to provide services under their MCH applications. Participation in community assessment and planning is a major component in assuring the health of women and children in the contract service area.

Additional information

For more information on the CHNA & HIP process, refer to the IDPH website at www.idph.state.ia.us/chnahip/default.asp.

Section 400

Fiscal Management

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401 Financial Accountability

AUTHORITY: 45 CFR 96, 45 CFR 92, 45 CFR 74

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 401—OCTOBER 2008

Contract requirements

The MCH contract agency is expected to comply with the following financial accountability requirements.

1. Written financial policies and procedures including, but not limited to
 - Supply distribution
 - Purchasing, bidding and selection
 - Check writing and control
 - Billing
 - Accounting/bookkeeping
2. Expenditure controls to prevent over-billing of annual budgets
3. Valid, approved time records for project staff and volunteers that clearly indicate the amount of time the individual spends in each program area. All volunteer time must be fully documented and approved by the individual whose time is used for match.
4. Use of generally accepted accounting principles
5. An independent financial audit completed annually. This requirement is applicable to subrecipients of federal funds who are required to have an audit made in accordance with the provisions of OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations.
6. Required Accounting Records including
 - Cash receipts register: The cash receipts register lists each receipt of cash or check with date received, payor's name, brief description, amount received and account credited.
 - Cash disbursements register: The cash disbursements register lists each disbursement in check number order with date paid, payee, check number, amount paid and account charged.
 - General ledger: The general ledger summarizes the monthly

- postings from cash receipts and cash disbursements registers by general ledger account, with adequate identification of expenses by each grant or contract.
- Journal entries: Journal entries contain explanations and amounts of any adjustments to the general ledger accounts.
 - Chart of Accounts: A listing of the accounts available in the general ledger in which to record entries.
 - Payroll time reports: Time reports show the hours worked on each funded program or grant and total individual effort. Records must be broken out by program activity on each time report.
 - Payroll register: The payroll register lists for each employee: gross pay, federal and state tax withheld, other amounts withheld, net pay and check number for each paycheck. Note: the payroll register may be included in the cash disbursements register at small agencies.
 - Individual earnings records: Individual earnings records list cumulative remaining during the year for each employee.
7. Expense documentation: The MCH contract agency and subcontractor must keep the following documents on file.
- Bank statements and canceled and voided checks
 - Invoices and bills for purchases of supplies, equipment, telephone utilities, services, etc.
 - Travel claims with receipts for commercial transportation, meal and lodging costs reimbursed to employees
 - Time reports and payroll registers
 - Copies of leases for office, equipment and vehicle rentals
 - Tax deposit receipts for withholding tax payments
 - Copies of monthly and final expenditure reports submitted to the Iowa Department of Public Health (IDPH)
 - Copies of contracts, budgets, amendments and all related correspondence from IDPH
 - Documentation of the methodology used for the allocation of costs
8. Internal control system established by management that is designed to provide reasonable assurance regarding the achievement of objectives in the following categories:
- Effectiveness and efficiency of operations
 - Reliability of financial reporting
 - Compliance with applicable laws and regulations

Accountability procedures

The following accountability procedures must be followed.

1. Expenditures paid by check should be made using prenumbered checks.
2. All receipts (cash and checks) are listed individually and

- deposited in the bank account intact and timely.
3. Bank reconciliations should be prepared monthly and reviewed and approved by a person who is not responsible for receipts or disbursements.
 4. If one individual has control over all cash functions (receiving funds, making deposits, reconciling bank statement, making payment, preparing payrolls), the employee must be bonded.
 5. If the MCH contract agency has more than one program, a plan for the allocation of costs must be established to indicate how costs are distributed equitably to each program. Formal accounting records that will substantiate the propriety of eventual charges will support all costs included in the plan. The allocation plan should cover all joint costs of the MCH contract agency. This includes costs to all programs of the MCH contract agency, which are to be included in costs of federally sponsored programs.
-

**Cost
allocation
plan**

The allocation plan must contain the following.

1. The nature and extent of services provided and their relevance to the program.
2. The items of expense to be included.
3. The methods to be used in distributing costs.
4. An annual review of the plan and necessary revisions.



402 Maternal and Child Health Cost Analysis

AUTHORITY: 2 CFR PART 225, *COST PRINCIPLES FOR STATE, LOCAL AND INDIAN TRIBAL GOVERNMENTS (OMB CIRCULAR A-87)*; 2 CFR PART 230, *COST PRINCIPLES FOR NON-PROFIT ORGANIZATIONS (OMB CIRCULAR A-122)*; OR 2 CFR 215 *UNIFORM ADMINISTRATIVE REQUIREMENTS FOR GRANTS AND AGREEMENTS WITH INSTITUTIONS OF HIGHER EDUCATION, HOSPITALS AND OTHER NON- PROFIT ORGANIZATIONS (OMB CIRCULAR A-110)*;

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 402 – OCTOBER 2009

Overview

Each year MCH contract agencies are required to determine their cost for providing all MCH core public health services, submit the cost analysis to IDPH and maintain that analysis on file at their agency.

Core public health services include:

- infrastructure building services
- population-based services
- enabling services
- direct care services

Services are billed based on the source of reimbursement, not the level of the service on the MCH Pyramid. For example, a reimbursement source may pay for some enabling services and not others.

Costs included in this analysis are reimbursed in different ways:

1. billable as fee-for-service to public or private sources including Medicaid, IDPH, private insurance and Early Childhood Iowa; or
2. reimbursed as “other public health” services by submitting expenditures to IDPH following a pre-approved plan.

The information from the cost analysis is utilized to set the fees for billable and non-billable services and reflects the actual cost of providing those services.

Other payers must be billed the same cost as Medicaid. Services provided to MCH clients that are not reimbursed by Medicaid or other third party payers are billed to the client based on the sliding fee scale. Co-pays and deductibles from third party payers are also billed to the

client based on the sliding fee scale. As Title V MCH service providers, contract agencies may choose to bill Medicaid and not bill private third party payers for services [“Free care principle” of Title XIX, Section 1902(a)(11) (B)]. The amount of reimbursement from Title V for these services will not exceed the Medicaid rate of reimbursement.

Services included in the MCH cost analysis

Billable as fee-for-service

Billable service codes open to Maternal Health Centers and Child Health Screening Centers are specified by the Iowa Department of Human Services in provider policy manuals found at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/MedProvider.htm#All%20Provider%20Chapters or by the Iowa Department of Public Health (IDPH). Services included in the cost analysis are based on the codes specified in the respective provider manual and as approved in writing by duly authorized department representatives.

Effective February 1, 2009, the following services are reimbursed by IDPH as fee-for-service as provided for in the state inter-agency agreement between IDPH and the Iowa Medicaid Enterprise:

- Child health
 - Presumptive Eligibility for Children
 - Informing
 - Re-informing
 - Care coordination including dental care coordination
 - Home visit for care coordination
- Maternal health
 - Outreach – presumptive eligibility for pregnant women
 - Care coordination, including dental care coordination, for pregnant women
 - Home visit for care coordination

The information required to determine costs must be retrievable from the MCH contract agency accounting system, time studies, utilization reports from agency service records and electronic data systems such as the Iowa Women’s Health Information System (WHIS) and the Iowa Child and Adolescent Reporting System (CAREs).

Reimbursed as “other public health” services

Other public health service costs are incurred by the MCH contract agency for maternal and child health contracted activities that are not billable to Medicaid or other third party payers. These costs include some, but not all, services associated with providing infrastructure

building, enabling and population-based services. Expenses are separate from those that are used to establish fee-for-service costs for services provided to individual clients. These costs may be reimbursed from Title V or other maternal and child health grants or contracts.

Note: "Other public health" service does not refer to services or programs provided outside the MCH contract such as WIC, the lead grant, Early Childhood Iowa or immunizations funded through public health nursing.

Method for completing the MCH cost analysis

To maintain consistency of cost determination among MCH contract agencies, the MCH Cost Analysis is completed using the methodology and forms designated by IDPH. The current methodology uses a cost center approach that distributes the various costs (expenses) of the services offered by the MCH contract agency. The cost of providing services is then determined by using a Relative Value System. A guide and a workbook of forms for completing the cost analysis are provided by IDPH. The Cost Analysis Guide, accompanying materials and workbooks are posted on the MCH Project Management Tools website at http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.

Submitting the MCH cost analysis

The MCH Cost Analysis is submitted to IDPH at the beginning of each contract year. The billing rate established through the cost analysis corresponds to the federal fiscal year (FFY) and therefore, begins October 1st and ends September 30th each year. Therefore, no bills for services provided after September 30th may be submitted to Medicaid or IDPH until the cost analysis for the next fiscal year is submitted and needed corrective actions are made by the MCH contract agency. For example, bills may be submitted for services provided through September 30, 2009; however, services provided in October 2009 must not be submitted until the FFY 2010 cost analysis has been submitted to IDPH, the review has been completed and any appropriate corrections are made. Likewise, any bills submitted for services which may have been denied in FFY 2009 must be resubmitted at the FFY 2009 established cost, even if the resubmission occurs in FFY 2010.

If circumstances change during the year, an MCH contract agency may submit a revised cost analysis report with prior notice and approval from the IDPH.

Accounting records are kept on an accrual basis. This means recording revenue when it is earned and expenses when incurred. Financial and statistical records to document the validity of the

analysis must be maintained for five years. Policy 408 of this manual provides additional details regarding retention requirements of fiscal records.

Time studies Time studies to justify salaries are required by the Office of the Inspector General for Medicaid and the federal Office of Management and Budget (OMB). Continuous time studies must be completed and maintained on file in each participating MCH contract agency. For consistency, the designated MCH Time Study form must be used. Guidelines for completion of the time study are available from IDPH. Exceptions may be permitted if approval was obtained prior to initiation of the alternative time study format. Policy 205 of this manual provides directions for requesting an exception to policy.

Transportation plan The costs for client transportation to health care services are reported on a separate form and are not part of the Excel workbook for cost analysis. The Transportation Cost Report is submitted with the Cost Analysis. Costs are based upon the current rate for transportation to a medical or dental Medicaid provider within the community (in town). The rates must be reasonable and reflect the fair market value for the service in the community. A plan must be submitted with the MCH Cost Analysis using the Transportation Cost Report form provided. For each code, note the days and hours of the week the service is provided and the rate that is charged for that type of transportation. Costs are calculated for a round trip. Refer to the Maternal Health Services Summary and Child Health Services Summary for transportation guidelines. The documents are posted on the MCH Project Management Tools website at http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.

Service codes for round trip transportation include:

- A0110: Non-emergency transportation by bus intra- or interstate carrier
- A0100: Non-emergency transportation, taxi intra-city
- A0130: Non-emergency transportation wheelchair van
- A0090: Non-emergency transportation per mile volunteer, interested individual, neighbor
- A0120: Non-emergency transportation mini-bus, mountain area transports, other non-profit transportation systems
- A0170: Transportation, Ancillary: Parking fees

Legal The “Iowa MCH Cost Analysis” follows the principles and standards for

authority

determining costs as found in 2 CFR Part 225, *Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87)*; 2 CFR Part 230, *Cost Principles for Non-Profit Organizations (OMB Circular A-122)*; or 2 CFR 215 *Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals and other non-profit organizations (OMB Circular A-110)*; or other guidance depending on the MCH Contract agency's organizational structure. These documents may be accessed at the Government Printing Office Federal Digital System website at www.gpo.gov/fdsys/



403 Budget Revisions

AUTHORITY: CONTRACT GENERAL CONDITIONS

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 403—OCTOBER 2008

Overview

The budget is part of the contract between the MCH contract agency and IDPH. The budget is developed in accordance with the RFP or RFA of the corresponding fiscal year. MCH contract agencies must notify IDPH of any contract changes and receive approval from IDPH for the changes. MCH contract agencies must obtain approval for budget revisions by the date specified in the contract. If no date is specified in the contract, the MCH contract agency must obtain approval for budget revisions by the last business day in September.

Revisions requiring prior written approval

Prior written approval is required for a budget revision under the following conditions:

- Any change in a line-item cost specifically identified in the Special Conditions of the contract as being restricted.
- The opening of any line item not in the approved budget.
- The purchase of equipment costing \$5000 or more and possessing a useful life expectancy of greater than one year. Equipment and/or supplies costing less than \$5000 may be purchased without prior approval from IDPH (per General Contract Conditions).
- Any change of ten percent (10%) or more of the total budget amount for a program (i.e., CH, MH, FP, CH-dental, I-Smile™, *hawk-i* Outreach). At no time will a specific program be over expended. Budget categories are identified in the most current RFP and RFA documents.

A request of budget revisions must include:

- The program budget with the requested changes included
- Justification for the requested changes
- Description of what dollar amounts were changed, moved or adjusted

If the requested revision reduces the amount on the contract face sheet, provide the proposed total. Budget revisions initiated on the

part of the MCH contract agency that increase the amount of the total grant funds will not be accepted.

All proposed budget revisions must be sent in writing (hard copy or email) to the chief(s) of the Bureau of Family Health and/or the Bureau of Oral and Health Delivery Systems at:

321 E 12th Street
Lucas State Office Building
Des Moines, Iowa 50319

**Revisions not
requiring
prior written
approval**

Routine budget revisions include such items as changing cumulative line item amounts of less than 10 percent of the total budget amount for a program, revising the “other funds” categories and changing a single category of personnel of less than .20 FTE. Routine budget revisions are those that do not substantively change the program plan.

Prior approval from IDPH is not required for routine budget revisions. However, routine budget revisions must be recorded in the approved budget. The MCH contract agency must notify the chief of the Bureau of Family Health or Bureau of Oral and Health Delivery Systems in writing with explanation of the change and the corresponding revised budget pages. Year-end expenditures will be compared against the revised line item amount.



404 Program Income

AUTHORITY: 45 CFR, PART 74.24; IOWA ADMINISTRATIVE CODE 641 IAC 76.13(2)

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 404—OCTOBER 2008

Definition

Program income is defined as gross income earned by the MCH contract agency resulting from activities related to fulfilling the terms of the contract. It includes, but is not limited to, such income as fees for service, third-party reimbursement and proceeds from sales of tangible, personal or real property.

Program income may be used for allowable costs of the MCH contract agency. A spending plan must be approved by IDPH for use of program income in excess of 5 percent above the amount approved in the program budget. Program income must be used before using the funds received from IDPH. Excess program income may be retained to build a three-month operating capital.

Other sources of funding

The MCH contract agency must develop other sources of financial support for program activities, including the following:

- Recover all third-party revenues to which the MCH contract agency is entitled as a result of services provided.
- Garner other available federal, state, local and private funds.
- Charge clients according to their ability to pay for services provided, based on a sliding fee schedule. The sliding fee schedule must be based on standardized guidelines provided by IDPH. Any changes from these guidelines must have prior written approval by IDPH.

Client billing and collection procedures must be consistent with those established and provided by IDPH. Services funded partially or completely by IDPH will not be denied to a person because of his or her inability to pay a fee for the service. Individual and/or immediate family income and family size are used in developing the sliding fee schedule.

The MCH contract agency must report to IDPH, within forty-five days, any funding sources developed in addition to those shown in the application for funding.



405 Documentation of Local Match

AUTHORITY: 45 CFR, PART 74.23 ; IOWA ADMINISTRATIVE CODE 641 IAC 76.13(4)

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 405—OCTOBER 2008

Eligibility overview

The provisions of 45 CFR, Part 74, Subpart C define terms, set standards of allowability and valuation, and establish procedures for MCH contract agency documentation of local match. Sources that may be used for matching funds are reimbursement for service from third parties such as insurance and Title XIX, client fees, local funds from non-federal sources or in-kind contributions. In-kind contributions must be documented in accordance with generally accepted accounting principles.

Charges for property purchased completely with federal funds and any portion of property purchased in part by federal funds are not permissible for inclusion as local match unless otherwise authorized by federal legislation. However, operating costs (such as housekeeping and maintenance, protection, utilities, etc.) may be included with adequate supporting documentation, even though valuation may be in the form of a square footage rate along with unallowable property charges. The value of volunteer labor and donated services may be included as part of local match and must be documented by the same method that the MCH contract agency uses for its paid employees. The valuation used for personal services would ordinarily be the value placed on the task performed and not necessarily the time rate of the individual rendering the service.

In general, local match, whether in cash or in-kind represents the portion of the MCH contract agency costs not borne by IDPH. The basis for determining valuation and charges for all elements of local match, including personal services, materials, equipment and realty, must be documented in a manner acceptable to IDPH.

Fees collected from Title XIX, and/or any other private or third party source, must be reported to the state when collected and must be expended on program-related activities. Subcontractors are required to report program income to the MCH contract agency. The MCH contract agency is required to report program income monthly to IDPH. On the monthly expenditure report the MCH contract agency is

certifying, with an original signature, that the amount of match reported is available to IDPH to use as federal match. IDPH will consider all the match funds reported by the MCH contract agency as available for federal match, although IDPH may elect to use only a portion of the certified match for Title V.



406 Advances of Contract Funds

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76.13(3); CONTRACT GENERAL CONDITIONS
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 406—OCTOBER 2008

Advances

MCH contract agencies may request an advance of up to one-sixth (1/6) of their contract funds at the beginning of a contract year with justification. The amount of any advance will be deducted prior to the end of the contract year.

Cash advances must be maintained in interest-bearing accounts. The MCH contract agency must allocate interest earned on cash advances to the program for which the cash advance was received. All interest earned on cash advances must be remitted to IDPH on a quarterly basis or more frequently if requested by IDPH. Interest amounts up to \$250 per contract period in the aggregate for all federally funded programs may be retained by the MCH contract agency for administrative expenses only.

The quarterly interest earned statement must be sent to:

Chief, Bureau of Family Health
Iowa Department of Public Health
Lucas State Office Building, 5th floor
321 East 12th Street
Des Moines, IA 50319

The Remittance of Interest Earned form is located in appendix A9 of this manual.



407 Reimbursement of Expense

AUTHORITY: IOWA CODE 8A.502
EFFECTIVE DATE: JANUARY 19, 2012
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REPLACES: 407—OCTOBER 2008

Electronic expenditure workbook

MCH contract agencies are reimbursed for expenses incurred by submitting a monthly expense report in the Electronic Expenditure Workbook (EEW) located in the SharePoint Service Contract Center. Each monthly expenditure report must include an electronic signature of an individual authorized by the MCH contract agency's SharePoint user memorandum of understanding (MOU).

The Iowa Department of Public Health (IDPH) provides the EEW to the MCH contract agency prior to the start of the contract year. An example of the first page of an EEW is provided in appendix A22 of this manual.

The EEW is an Excel spreadsheet form that is used by the MCH contract agency to report the amount of grant funds expended in each line item per program (e.g., MH, CH, FP, etc.) each month. The EEW is also used by the MCH contract agency to report the amount of funds billed to "other" funding sources (e.g., Title XIX) and received from "other" funding sources each month.

An EEW workflow is due 45 days after the month of expenditure. A summary of the expenditure reports is included in the EEW and serves as the year-end expenditure report as specified in the contract.



408 Fiscal Record Retention

AUTHORITY: 45CFR PART 74
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 408—OCTOBER 2008

Requirements The Iowa Department of Public Health requires that all accounting and financial records, programmatic records, supporting documents, statistical records and all records reasonably considered as pertinent to grants be retained for a period of five (5) years from the day the MCH contract agency submits its final expenditure report. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the five year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five (5) year period, whichever is later. Client records, which are non-medical, must be retained for a period of five (5) years from the day the MCH contract agency submits its final expenditure report, or in the case of a minor patient or clients, for a period of five (5) years after the patient or client reaches the age of majority.

Availability of records Federal regulations and the agreements between the state agency and the local MCH contract agency require that all records determined to be pertinent to the grant must be made available to representatives of the state and/or federal government for purposes of an audit, examination, excerpts and transcripts.



409 Client Eligibility for Medicaid Programs

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 75.1 (249A)

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 409—OCTOBER 2009

Definition

Medicaid (Title XIX) is a program that pays for covered medical and health care costs for certain individuals and families with low incomes and resources. The Medicaid program is administered by the Iowa Department of Human Services (DHS) and is financed by federal and state funds.

Eligibility for Medicaid is based primarily on the financial status of the applicant. Citizenship or immigration status and identity must be verified. The federal government requires states that participate in the Medicaid program to provide coverage for recipients of certain federally funded public assistance programs such as Supplemental Security Income (SSI) and Foster Care and Adoption Assistance. States also have the option of covering recipients of state-funded public assistance programs and various groups of people whose situations are similar but do not meet all the requirements.

Members covered by the Family Medical Assistance Program (FMAP)

The Medicaid program is available to parents and their children under age 18 living with them, children under age 21 and pregnant women. A family may be eligible for Medicaid even though they are not eligible for FIP (Family Investment Program cash assistance). Medicaid is not automatically provided for a person or family who is eligible for FIP.

Resources are disregarded when determining eligibility for children under FMAP-related coverage groups. However, resources of the *entire* family are still considered when determining eligibility for adults.

Persons eligible for Medicaid under this program include the following:

- Specified relatives and their children in the home who meet financial and non-financial eligibility requirements
- Individuals under age 21 who meet financial and non-financial eligibility requirements (do not qualify as dependent children)
- Pregnant women and infants under one year of age if the family

income does not exceed 300 percent of the Federal Poverty Level (FPL). A woman who applies for Medicaid before the end of her pregnancy and is determined eligible will receive Medicaid for 60 days during the postpartum period following the end of the pregnancy.

- Pregnant women age 19 and older have a liquid resource limit of \$10,000. Once a pregnant woman is determined eligible for Medicaid, increases in income are disregarded throughout the remainder of her pregnancy and postpartum period.
- Infants born to pregnant women enrolled in Medicaid are automatically enrolled for one year and remain eligible if they remain an Iowa resident
- Children age one through 18 whose family income does not exceed 133 percent of the FPL

Members covered under the Supplemental Security Income (SSI) Program

The Medicaid program covers all beneficiaries of Supplemental Security Income (SSI) cash assistance. SSI assistance is available for persons who are aged, blind or disabled and is administered by the Social Security Administration. The Medicaid program also covers aged, blind or disabled persons who would be eligible for SSI if certain conditions were met (e.g., if the cost of living increases in their Social Security benefits are not counted).

Certain people residing in medical institutions

People who reside in a medical institution (i.e., a hospital, nursing facility, psychiatric institution or intermediate care facility for the mentally retarded) may be eligible for Medicaid. These individuals must meet Medicaid eligibility through FMAP-related or SSI-related coverage groups. Residents of institutions who have not been found eligible for Medicaid prior to being admitted to a medical institution may need to reside in a medical institution for a full calendar month before becoming eligible for Medicaid.

There is a special income limit in effect for Medicaid recipients in medical institutions. To be eligible in terms of income, the recipient's monthly income may not exceed 300 percent of the basic SSI benefit. If an individual's income exceeds 300 percent of the basic SSI benefit, the individual may obtain Medicaid eligibility by establishing a Medical Assistance Income Trust. The basic SSI benefit limit generally increases on January 1 of each year, as increases occur in the basic SSI benefit.

Recipients of State Supplementary

People who receive State Supplementary Assistance are eligible for Medicaid. State Supplementary Assistance is a state program that makes a cash assistance payment to certain SSI beneficiaries and to

Assistance (SSA)

persons that are not eligible for SSI due to income slightly exceeding the SSI standard if they have a specific need that is covered by the State Supplementary Assistance program.

The monthly SSA payment supplements the person's income to meet the cost of special needs such as residential care, home health care, family-life home care, a dependent person, or special needs due to blindness.

Children in foster care or subsidized adoptions

Children in foster care or subsidized adoptions are covered by Medicaid if DHS is wholly or partially financially responsible for their support. Under certain circumstances, Iowa offers Medicaid coverage to children in Iowa from other states.

Members under the Medically Needy program

The Medically Needy program provides medical coverage for people that would qualify for Medicaid programs (other than IowaCare), except that

- They have slightly too much income or resources, or
- They have substantially higher incomes but have unusually high medical expenses.

The Medically Needy program covers individuals that are

- Pregnant
- Under age 21
- Caretaker relatives
- Aged
- Blind
- Disabled

Individuals who meet all eligibility factors for the Medicaid program except for income are allowed to reduce their excess income through incurred medical expenses. This process is called spend down. Medical expenses used for spend down are considered as a deductible and are not paid by Medicaid.

People who have a Medically Needy spend down obligation are 'conditionally eligible' for Medicaid until they have verified enough medical expenses to meet their spend down for the certification period. A Medical Assistance Eligibility Card will be issued for Medically Needy recipients who have met their spend down obligation.

When a member has a spend down obligation to meet, claims for the conditionally eligible or responsible person are submitted to the Iowa Medicaid Enterprise just as if the person were eligible for Medicaid,

using claim forms or electronic billing. Individuals who have successfully reduced their excess income through spend down are notified of the bills used for spend down for which they are personally responsible.

Medically Needy recipients are entitled to receive all services covered by Medicaid except:

- Care in a nursing facility or skilled nursing facility
- Care in an institution for mental disease
- Care in an intermediate care facility for the mentally retarded
- Services for rehabilitative treatment

Emergency services for undocumented persons

Federal immigration and naturalization laws provide limited Medicaid benefits for treatment of emergency medical conditions for certain undocumented persons living in the United States. To be eligible for Medicaid benefits, the individuals must meet the income and resource eligibility requirements and must have had or currently have an emergency medical condition. "Emergency medical condition" means a medical condition of sudden onset (including normal labor and delivery) presenting acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably result in

- Placing the patient's health in serious jeopardy,
- Serious impairment of bodily function, or
- Serious dysfunction of any bodily part or organ.

Payment for treatment of an emergency medical condition is limited to services provided in a hospital, clinic, office or other facility (including an independent diagnostic laboratory or X-ray facility) that is equipped to furnish the required care after the onset of an emergency medical condition. To be payable, care must be provided during the **3-day period** beginning with the date the individual presented for treatment of the emergency condition.

Medicaid for Employed People with Disabilities (MEPD)

Medicaid for Employed People with Disabilities (MEPD) is designed to allow people with disabilities to work and continue to have access to medical assistance. Information about MEPD may be found at www.ime.state.ia.us/HCBS/MEPDIndex.html.

To qualify, individuals must:

- Be under the age of 65
- Be disabled (based upon SSA criteria, excluding the condition of Substantial Gainful Activity (SGA))
- Have earned income from employment or self-employment

- Have resources less than \$12,000 for an individual or \$13,000 for a couple
 - Have a net family income of less than 250 percent of the FPL
 - Pay a premium assessed for each month of eligibility if gross individual income is over 150 percent of the FPL
-

Women who need treatment for breast or cervical cancer

Medicaid is available to women who qualify under all of the following components:

- Under the age of 65
- Have been screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program
- Have been found to need treatment for breast or cervical cancer (for a cancerous or pre-cancerous condition)
- Do not have creditable medical coverage
- Are not eligible under a mandatory Medicaid coverage group

During the period of eligibility, the woman is entitled to full Medicaid coverage. Covered services are not limited to the treatment of breast or cervical cancer. Full Medicaid eligibility continues until the woman no longer receives treatment for breast or cervical cancer, turns age 65, is covered by other health insurance, is eligible under a mandatory coverage group, is no longer an Iowa resident or does not follow through with the annual review process.

Qualified providers can make a presumptive determination of Medicaid eligibility to facilitate the provision of care. The presumptive eligibility process allows for immediate health care for women likely to be Medicaid eligible. Presumptive Medicaid is full Medicaid and begins with the date the qualified provider makes an eligibility determination and generally continues up to the end of the next month.

Members under the Iowa Family Planning Network

The Iowa Family Planning Network (IFPN) provides limited Medicaid coverage for specific family planning related services. It is available to individuals who qualify under at least one of the following:

- Are capable of bearing children and who are not pregnant
- Were receiving Medicaid at the time their pregnancy ended
- Are of reproductive age (over age 12 and under age 45) and have countable income no greater than 200 percent of the FPL

Eligibility continues for 12 consecutive months beginning with

- The month after the postpartum period ends for women who had a pregnancy end while on Medicaid, or
 - The first month for which eligibility is established for women who have income at or below 200 percent of the FPL.
-

Individuals are eligible for limited Medicaid benefits that are either primary or secondary to family planning services. For the full list of services, refer to the All Providers Medicaid Manual, Chapter II Member Eligibility on the DHS website at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-ii.pdf.

**Members
under
IowaCare**

IowaCare is a limited health care program that covers adults ages 19-64 who would not normally be covered by Medicaid. This program covers some inpatient and outpatient services, physician and advanced registered nurse practitioner services, limited dental services, routine yearly physicals, smoking cessation and limited prescription drug benefits. All services must be received and ordered by a participating provider to be covered.

On October 1, 2010, the IowaCare Medical Home pilot was launched. Approximately 25,000 members were assigned to a medical home where they will receive routine care, preventive services and disease management at four designated clinics:

- Siouxland Community Health Center in Sioux City
- Peoples Community Health Clinic in Waterloo
- Broadlawns Medical Center in Des Moines
- University Hospitals and Clinics in Iowa City.

Plans for the future are to expand the program across Iowa using existing Federally Qualified Health Centers to effectively assign every IowaCare member to a centrally located medical home.

IowaCare is a Medicaid program that covers:

- Persons ages 19 through 64 who are not eligible for other Medicaid coverage groups and whose countable income is not more than 200 percent of the federal poverty level
- Pregnant women whose countable income is less than 300 percent of the federal poverty level and who can reduce their income to 200 percent of the federal poverty level with obligated medical expenses
- Newborn infants of women who were receiving IowaCare at the time of the newborn's birth

An IowaCare Medical Card is issued to persons determined to be eligible for IowaCare benefits. IowaCare members are assessed a premium based upon their income. Payment of the premium is a condition of eligibility unless a hardship exemption is requested.

Members who qualify for the Home and Community Based Services (HCBS) Waiver programs

HCBS waivers provide Medicaid and a variety of services in the eligible person’s home that are not available through regular Medicaid. Eligible people must meet Medicaid eligibility through FMAP-related or SSI-related coverage groups, including the special 300 percent of SSI income limit in effect for Medicaid recipients in medical institutions, depending on the waiver type. Eligible people must also be determined to need the type of care provided by a nursing facility (NF), skilled nursing facility (SNF), intermediate care facility for the mentally retarded (ICF-MR), or hospital.

There are currently seven HCBS waivers, targeting the following groups:

- People who have AIDS or have been infected with HIV (AIDS/HIV)
- People who have a brain injury (BI)
- People who are elderly (EW)
- People who are ill or handicapped (IH)
- People who have an intellectual disability (ID)
- People who have a physical disability (PD)
- Children who have a serious mental, behavioral or emotional disorder (CMH)

See section 413 in this manual for more information on the HCBS Waiver programs.

Presumptive eligibility determination for children

Children under the age of 19 who have been identified as being potentially eligible for Medicaid or *hawk-i* may be presumed eligible by a “qualified entity” and may receive temporary Medicaid coverage pending a formal eligibility determination by DHS. A child determined to be presumptively eligible is eligible for full Medicaid benefits during the presumptive period. See policy 410 for further information.

Presumptive eligibility determination for pregnant women

Qualified providers can make a presumptive determination of Medicaid eligibility to facilitate the provision of ambulatory health care including oral health care for pregnant women. The presumptive eligibility process allows for immediate access to health care for pregnant women likely to be Medicaid eligible. Presumptive Medicaid begins with the date the qualified provider makes an eligibility determination and generally continues up to the end of the next month. See policy 410 for further information.

Retroactive eligibility

An individual may be determined eligible for retroactive Medicaid benefits in any of the three months preceding the month in which

application was filed when

- The applicant has paid or unpaid medical expenses for covered medical services that were received during the retroactive period, and
- The applicant would have been eligible for Medicaid benefits in the month services were received if an application had been filed, regardless of whether the applicant is alive when the application is actually filed.

The applicant need not be eligible in the month of application to be eligible in any month of the retroactive period.

Exception: There is only one month of retroactive eligibility for IowaCare.

There is no retroactive eligibility for the Qualified Medicare Beneficiary program, the Iowa Family Planning Network, the Home and Community Based Waiver programs or presumptive Medicaid.

Referral of potentially eligible persons

If an individual has not applied for Medicaid, is unable to pay for services and appears to meet the requirements of eligibility as outlined above, advise the individual or their representative to contact the local DHS office. Addresses and phone numbers can be found at www.dhs.iowa.gov/Consumers/Find_Help/MapLocations.html .

For additional information on eligibility, refer to the All Providers Medicaid Manual, Chapter II Member Eligibility on the DHS website at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-ii.pdf.

Additional information is also available within the Policy Manuals as published by the Iowa Department of Human Services at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/MedProvider.htm#All%20Provider%20Chapters.



410 Presumptive Eligibility for Medicaid for Pregnant Women and Children

AUTHORITY: SOCIAL SECURITY ACT SECTION 1902.(2); OBRA 1986; PL 99-105, 9407; IC249.3LI
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 410 - OCTOBER 2008

Presumptive Eligibility for Medicaid for Pregnant Women

Purpose The goal of the Presumptive Medicaid Eligibility (PME) program is to ensure that pregnant women do not delay obtaining prenatal care or other needed ambulatory services (mental health services, dental services) while they are waiting for a formal Medicaid eligibility determination to be made by the Iowa Department of Human Services (DHS).

Eligibility Eligibility is based only on the woman's statements regarding her household income; a qualified provider can "presume" that a pregnant woman will be eligible for Medicaid. This makes it easier for the pregnant women to receive medical care and covers the cost of ambulatory prenatal care.

Only pregnant women can be presumed to be Medicaid eligible under this program. The number of other household members and their income will be taken into consideration when determining the pregnant woman's eligibility.

- Must be an Iowa resident
- Citizenship or qualified alien status is not an eligibility factor for pregnant women
- Gross income less than 300% of the Federal Poverty Level (FFY12), income limits are update annually around April 1 each year. Proof of income is unnecessary. May apply even if you think it 300% limit. Note: The unborn child(ren) is considered as an individual when determining household size.

Eligibility continues up to the last day of the month following the month of the presumptive eligibility determination.

If the pregnant women files a formal Medicaid application during the presumptive period and the application is pended by DHS,

presumptive eligibility continues until a decision is made on the application by DHS. If DHS denies the full Medicaid application during the presumptive period then the presumptive eligibility periods ends.

Qualified provider

A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets certain criteria. To become qualified, a provider must complete the Application for Authorization to Make Presumptive Eligibility Determinations, form 470-2579, and submit it to Iowa Department of Human Services. The provider will be notified in writing of DHS's decision to approve or deny the application.

Qualified provider responsibilities

A qualified provider should encourage women who are under insured or without insurance to apply. The responsibilities of the qualified provider include the following:

- Date stamp the application upon receipt
 - Determine presumptive eligibility based on statements provided by the applicant
 - Complete the necessary Iowa Medicaid Portal Access (IMPA) entries
 - Fully explain that the presumptive eligibility determination is not a formal Medicaid eligibility decision by DHS
 - Fully explain that it is the applicant's decision to apply for only presumptive eligibility or to apply for full Medicaid at the same time she applies for presumptive eligibility
 - Print the Notice of Decision (NOD) and give it to the applicant.
 - Keep a copy of the NOD in the applicant's chart
 - Notify the applicant of the presumptive eligibility decision
 - Assist the applicant in understanding the program
-

Miscellaneous

DHS "All Providers Manual" includes details about the presumptive Medicaid eligibility determination process. The manual now contains answers to many of the most frequently asked questions presumptive eligibility determination.

Here is a link to the relevant manual chapter:

www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-ii.pdf

- Technical Issues with the IMPA – Presumptive Portal: Report to IME Provider services 1-800-338-7909 or email
-

IMPAsupport@dhs.state.ia.us

- For questions related to the presumptive eligibility application process, contact the local office of the Iowa Department of Human Services. A directory of local DHS offices can be found on the DHS website at www.dhs.state.ia.su.
-

Presumptive Eligibility for Medicaid for Children

Purpose

The goal of presumptive Medicaid eligibility is to provide a process that allows children to obtain Medicaid-covered services while a formal Medicaid eligibility determination is being made by the Iowa Department of Human Services (DHS). A qualified entity can “presume” that a child will be eligible for Medicaid based on a family’s statements regarding their circumstances and income and grant temporary Medicaid eligibility during the presumptive period. During the presumptive eligibility period, the child is entitled to receive full Medicaid coverage.

Why is it important?

The Medicaid presumptive eligibility process is important because it ensures children do not delay in obtaining medical or oral health care.

Who receives Presumptive Medicaid Eligibility services?

Infants and children can be determined to be presumptively eligible for Medicaid by completing form 470-4855. A child will be eligible for Iowa Medicaid based on self-declaration by the family; therefore, not verified. All Presumptive applications are used to input information into a DHS system which will populate a Medicaid application that will be forwarded to DHS for an ongoing Medicaid eligibility determination for the children. During the formal Medicaid eligibility determination, DHS will verify income, citizenship, alien status, identity and other information as necessary.

What is a qualified entity (QE)?

A “qualified entity” (QE) is defined as individuals that are certified by the Iowa Department of Human Services (DHS) and are authorized to make presumptive eligibility determinations. QEs must be Medicaid providers or the employees of Medicaid providers. All Authorized employees will be required to be certified individually. Prior to being certified, each QE will be required to view the web-based training module.

Local **hawk-i** outreach coordinators may request authorization by contacting the state **hawk-i** outreach coordinator at the Iowa Department of Public Health. All others interested in certifying as a QE may request authorization through the IME Provider Enrollment Unit. Once approved, the QE will be given access to the presumptive eligibility section within the Iowa Medicaid Portal Access (IMPA) site.

How often does a QE need to be recertified?

Qualified entities who make presumptive eligibility determinations are required to be recertified annually. To be recertified, the QE must complete training electronically. Each authorized QE will be notified via email of the requirement to recertify 60 days in advance of their certification expiration date. This makes it necessary for each user have an individual email account to receive user-based notifications.

Each person authorized to make presumptive eligibility determinations will have a unique log-in and MUST NOT share their access authorization with others.

What is Iowa Medicaid Portal Access (IMPA)?

After becoming certified as a qualified entity you will be granted access to the Iowa Medicaid Portal Access (IMPA) site. On the IMPA site you will be able to submit applications, edit applications that have not yet been submitted to DHS and review applications previously submitted by you.

IMPA manages many different types of tools and applications. Signing up for IMPA is as simple as entering your name, telephone number and email address and setting up a password. There are no restrictions on who may sign-up to view the IMPA portal. Once registered, however, you must request access to each feature or tool. QE's for example will need to request access to the Presumptive Eligibility application.

The link on the screen will take you to the IMPA Home page.

What are the general eligibility requirements for PE for Children?

Presumptive eligibility for children is based on the following criteria.

The child must:

- Be under age 19
 - ✓ This means the applicants age as of the 2nd day of the month the application is being received, for example:
 - A child turns 19 on October 1st. They would be

considered a child through the month of September, but not in October. A child turns 19 anytime from October 2nd through 31. They would be considered a child through the month of October.

- Be an Iowa resident
- Be a citizen or qualified alien-undocumented children are not eligible
- Live in a household with gross income less than 300% of the Federal Poverty Level (FPL) based on the size of the household
- Not have received presumptive eligibility in past 12 months from the month the application is received by the QE
- Note: For emancipated minors – Do not count income or household members that are parents, stepparents or siblings. Only count the emancipated minor’s spouse and any children of the emancipated minor.
- An emancipated minor is defined as a person who is or has been married and the marriage has not been annulled or a person who the courts have released from the control of parents.

How often is a child eligible for PE?

The presumptive application for a child will be denied if the child has received presumptive eligibility in the past 12 months from the month the application is received by the QE.

What are the duties of the QE?

The qualified entity is required to:

- Date stamp the application with the date that it is received
- Clarify information on the application, if necessary.
 - ✓ For instance- if the writing is not legible or important information is missing (such as the child’s social security number- and he/she is not exempt from the ss# requirement) that information must be noted and clarified before the application can be entered into the PE system.
- Inform the household that all presumptive applications are referred to DHS for an ongoing Medicaid or hawk-i eligibility determination for the children. During the formal Medicaid eligibility determination, DHS will verify income, citizenship, alien status, identity and other information as necessary.
- Enter information from the application into the Iowa Medicaid

Provider Access Presumptive eligibility application system within 3 business days.

- ✓ Information must be entered EXACTLY as it is written on the signed application.
- ✓ Data entries made by the QE are used to electronically calculate presumptive eligibility. All information on the application is self-declared by the household; therefore-is not verified.
- Provide a Notice of Decision (NOD) to the applicant within 2 business days of the date stamped on the application. The NOD reflects the eligibility decision based on the information entered from the application.
- Maintain documentation to support the presumptive eligibility decision. This may include, but is not limited to the application, clarification of any information provided by the household and a copy of the NOD.
- Adhere to the record retention guidelines set forth by IME/DHS.

What form does the family need?

A person requesting presumptive eligibility for a child must complete a Presumptive Health Care Coverage for Children Application form 470-4855 (2/10).

What should I do with the forms?

Maintain documentation to support the presumptive eligibility decision. This may include, but is not limited to the application, clarification of any information provided by the household and a copy of the NOD.

When does PE for children coverage begin?

Eligibility for PE for children begins no earlier than the date the application was completed and received. There is no retroactive eligibility for PE.

How long does coverage last?

Medicaid usually begins the date the QE determines the child is eligible and continues through the last day of the following month or until a formal decision is made. This means that it is possible that the presumptive period may continue beyond the end of the next month.

However, presumptive eligibility can end at any time without notice if

it is determined the child is not eligible.

Does the family have appeal rights?

- There are no appeal rights for people who apply for presumptive eligibility because a presumptive period is temporary and not considered a formal Medicaid eligibility determination.
 - Appeal rights are given with formal or ongoing Medicaid eligibility determinations.
-

Record retainment?

- A QE will keep records of the presumptive eligibility determinations for a period of three years for audit purposes.
-

Who do I contact if there is a technical issue with IMPA or I have questions about the family's application?

- For technical issues please contact the IME Provider Services unit by emailing the email address on the screen.
 - For questions related to the presumptive eligibility criteria or application please contact your local DHS office. A directory of all local DHS offices can be found online at www.dhs.state.ia.us
 - For more information on Presumptive Eligibility Determination for children, refer to the All Providers Medicaid Manual, Chapter II Member Eligibility on the DHS website at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-ii.pdf
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411 Reimbursement for Nutrition Counseling Services

AUTHORITY: MEDICAID PROVIDER MANUAL

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 411 - OCTOBER 2009

Overview

Child Health Screening Centers are eligible for Medicaid reimbursement of nutritional counseling services for children age 20 years and under, when provided by licensed dietitians either employed by or contracted with the child health contract agency. Services are reimbursed when a nutritional problem or a condition of such severity warrants nutritional counseling beyond that normally expected as part of standard medical management. These services require medical necessity and are above and beyond the standard WIC package of services provided by licensed dietitians.

The following listing provides examples of diagnoses that may be appropriate for therapeutic nutritional counseling. This is not an all-inclusive list. Other diagnoses may be appropriate.

- Chronic gastrointestinal tract problems, such as chronic constipation, colitis, liver dysfunction, ulcers, tumors, gastroesophageal reflux, malabsorption disorders or chronic diarrhea associated with nutrient loss, short bowel syndrome or celiac disease
- Chronic cardiovascular problems and blood and renal diseases, such as kidney failure, heart disease or hypertension
- Metabolic disorders such as diabetes, electrolyte imbalance or errors of metabolism such as phenylketonuria (PKU)
- malnutrition problems such as protein, mineral, vitamin and energy deficiencies; failure to thrive; anorexia nervosa; or bulimia
- Autoimmune diseases
- Other problems and conditions such as food allergy or intolerance, anemia, pregnancy, drug-induced dietary problems, nursing-bottle mouth syndrome, obesity, inadequate or inappropriate techniques of feeding, inadequate or excessive weight gain, neoplasms, cleft palate or cleft lip, or feeding problems related to breastfeeding management

Billing

Therapeutic nutrition counseling must be provided by a licensed

**nutrition
counseling
services**

dietitian employed by or contracted with a Child Health Screening Center, physician or outpatient hospital. The child health contract agency must have a written contractual agreement, including expectations for documentation, if the dietitian is not an employee of the Child Health Screening Center.

For children eligible for the WIC Program, Medicaid reimbursed nutrition counseling is only available when WIC services cannot meet the medically necessary needs of the child. WIC eligible children must first be referred to WIC.

When billing, the applicable diagnosis code must be entered on the claim. Medicaid reimburses this service based on a 15-minute unit.

**MediPASS
members**

If a Medicaid eligible child is assigned to a MediPASS (Medicaid Patient Access to Services System) physician, the referral to a licensed dietitian for nutrition counseling services must be approved by the MediPASS provider.



412 Client Eligibility for Health Insurance Premium Payment (HIPP) Program

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 75.21(249A)

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 412—OCTOBER 2009

Definition

The Health Insurance Premium Payment (HIPP) Program is available to individuals or family members on Medicaid (Title XIX). The HIPP Program helps families get or keep health insurance by paying for the cost of premiums, co-insurance and deductibles when it is determined to be cost effective.

Cost effectiveness means it would cost less for the Iowa Department of Human Services to buy the insurance to cover medical costs than for Medicaid to pay for all medical care. The HIPP Program considers the average amount of Medicaid funds spent on a comparable family and compares this to what it would cost Medicaid to purchase the insurance. If someone has a medical condition which causes their costs to be higher than the average, then the program will consider the specific bills paid in the prior 12 months to project expected expenses. This could make payment of the premiums cost-effective.

Eligibility

To be eligible for the HIPP program, the following must apply:

- An individual in the home must be Medicaid enrolled.
- They must have health insurance or be able to get health insurance coverage through their employer or have an individual health insurance policy. (The HIPP program does not find health insurance for individuals.)
- The health plan must be cost-effective as defined above.

Determination

The HIPP program pays for *family* coverage only when it is the only way the Medicaid-eligible family members, usually children, can be insured. HIPP will pay for the cost of insurance premiums, coinsurance and deductibles for the people in the family on Medicaid. Medicaid will cover those services not covered by the insurance plan. Members of the family who are not eligible for Medicaid may also be

covered under the employer's health plan or by an individual plan if HIPP must pay for these individuals in order to get coverage for the Medicaid-eligible persons. However, the HIPP program does not pay co-insurance or deductibles for non-Medicaid eligible family members nor are these non-Medicaid-eligible people used in the cost-effective determination.

If HIPP has determined that the group health insurance available through an employer is cost-effective, employees are required to participate in the plan as a condition of Medicaid eligibility. Failure to enroll in the plan when notified by HIPP to do so or failure to provide information necessary to determine eligibility may result in cancellation of Medicaid benefits. Only the policyholder is subject to loss of Medicaid for non-cooperation with HIPP. The Medicaid benefits of a spouse or children cannot be sanctioned because of the non-cooperation of the policyholder.

Enrollment in a plan *other than* group health insurance through an employer is not required. However, if it is determined cost-effective, HIPP will pay the cost of premiums.

HIPP will continue to pay premiums for health insurance as long as recipients are eligible for Medicaid and as long as it is determined to be cost effective. HIPP will regularly review the cost-effectiveness of a policy for increases in the cost of premium, changes in covered services or changes in members covered under the policy.

Questions

For questions, use the following resources:

- **Phone:** 1-888-346-9562 or 515-974-3282 in the Des Moines area
- **Fax:** 1-515-725-0725
- **Email:** hipp@dhs.state.ia.us
- **Internet address:** www.dhs.state.ia.us/hipp

Application

Application can be made by:

- Contacting the local DHS office for assistance.
- Calling the above number and staff will assist with completing an application.
- Completing an application found at www.dhs.state.ia.us/docs/HIPPapp.pdf and mailing or fax it to:

Iowa Medicaid Enterprise (IME)
HIPP Unit
P.O. Box 36476
Des Moines, IA 50315-9907

Fax: 1-515-725-0725

**AIDS/HIV
Health
Insurance
Premium
Payment
(HIPP)
Program**

The AIDS/HIV Health Insurance Premium Payment (HIPP) Program helps to ensure that persons living with AIDS/HIV related illness can continue their health insurance coverage by paying the health insurance premiums when these individuals are too ill to work.

To qualify for services under the AIDS/HIV HIPP program, the individual must:

- be ineligible for Medicaid
- be a resident of Iowa
- provide a doctor's certification that the person's ability to work is impaired due to AIDS or HIV-related illness.
- be the policyholder of the health insurance plan or be a dependent on their spouse's health plan.
- have "liquid" assets (cash, stocks, bank accounts, etc.) of less than \$10,000.
- meet the income limits; Gross income may not exceed 300% of the federal poverty level.

To apply for the AIDS/HIV HIPP Program, the individual may contact the local DHS office or call the HIPP customer service number at 1-888-346-9562. All communications regarding this program are held in the strictest confidence.



413 Client Eligibility for Medicaid Home & Community Based Services Waivers

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 75.22 AND 441 IAC 77.37
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 413 - OCTOBER 2009

Definition

Iowa's Home & Community Based Services (HCBS) waivers are Medicaid programs from the federal government which have rules set aside or 'waived'. In order to extend Medicaid eligibility and to expand the range of services, the federal government must waive certain Title XIX regulations. This gives individuals more choice about how and where they receive services. Waiver programs are available to persons with disabilities, as well as older Iowans who need services and supports to remain in their own homes and avoid placement in a medical institution.

Iowa currently has seven HCBS waivers. Individuals must meet Medicaid's eligibility criteria for each waiver to become enrolled. Individuals enroll through the local office of the Iowa Department of Human Services.

Service elements

All waivers include the following common service elements:

- **Service coordination:** Service coordination is provided by a case manager/service worker who helps plan for and assists the individual to gain access to needed services and supports
- **Individual Service Plan:** The Individual Service Plan includes information about the person, goals and steps that the person and their support team need to pursue to achieve the goals. The individuals on the support team include the client, the case manager/service worker and others.
- **Quality assurance:** Quality assurance activities assure that the individual is satisfied with the services and supports and that they are moving toward achieving the goals identified in the Individual Service Plan. Quality assurance activities also assure that HCBS funds are used appropriately and meet federal and state requirements.
- **Easy access:** Individuals should be able to find and get the supports that they need.
- **Flexible supports:** Supports should be creative and effective to

best meet the individual's needs in the most efficient manner possible.

- Person centered approach: Individuals should feel respected, valued and an equal partner in the design and delivery of the supports.
- Health and safety: Providers will provide high quality supports. These supports allow individuals to remain healthy and safe while making informed choices, trying new experiences, taking reasonable risks and assuming new challenges and responsibilities.

Waivers

The following six HCBS waivers could apply to individuals served by MCH contract agencies. (The HCBS Elderly (E) Waiver is excluded from this list, as this waiver serves elderly individuals at least 65 years of age.)

**HCBS
AIDS/HIV
(AH) Waiver**

The AIDS/HIV (AH) waiver provides services for persons who have an Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) diagnosis. The following services are available:

- Adult day care
- Consumer directed attendant care
- Counseling services
- Home delivered meals
- Home health aide
- Homemaker
- Nursing
- Respite

For more information on the HCBS AIDS/HIV Waiver, see the *Home and Community Based Services Brochure* online at www.ime.state.ia.us/docs/HCBSbrochure102606.pdf and also at www.ime.state.ia.us/HCBS/help_ownhome.html.

**HCBS Brain
Injury (BI)
Waiver**

The HCBS BI waiver provides services for persons who have a brain injury diagnosis due to an accident or illness. An applicant must be at least one month of age but less than 65 years of age. The following services are available:

- Adult day care
- Behavioral programming
- Case management
- Consumer directed attendant care
- Family counseling and training
- Home and vehicle modification

- Interim medical monitoring and treatment
- Personal emergency response
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living
- Supported employment
- Transportation

For more information on the HCBS BI Waiver, see the *Home and Community Based Services Brochure* online at www.ime.state.ia.us/docs/HCBSbrochure102606.pdf and also at www.ime.state.ia.us/HCBS/help_ownhome.html.

HCBS III and Handicapped (IH) Waiver

The HCBS IH waiver provides services for persons who are blind or disabled. Applicants must be less than 65 years of age. The following services are available:

- Adult day care
- Consumer directed attendant care
- Counseling
- Home and vehicle modification
- Home delivered meals
- Home health aide
- Homemaker
- Interim medical monitoring and treatment
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite

For more information on the HCBS IH Waiver, see the *Home and Community Based Services Brochure* online at www.ime.state.ia.us/docs/HCBSbrochure102606.pdf and also at www.ime.state.ia.us/HCBS/help_ownhome.html.

HCBS Intellectual Disabilities (ID) Waiver

The HCBS MR/ID waiver provides services for persons with a diagnosis of mental retardation. The following services are available:

- Adult day care
- Consumer directed attendant care
- Day habilitation
- Home and vehicle modification
- Home health aide
- Interim medical monitoring and treatment
- Nursing

- Personal emergency response
- Prevocational
- Respite
- Supported community living
- Supported community living – residential based
- Supported employment
- Transportation

For more information on the HCBS ID Waiver, see the *Home and Community Based Services Brochure* online at www.ime.state.ia.us/docs/HCBSbrochure102606.pdf and also at www.ime.state.ia.us/HCBS/help_ownhome.html .

**HCBS
Physical
Disability (PD)
Waiver**

The HCBS PD waiver provides services for persons with a physical disability. An applicant must be at least 18 years of age, but less than 65 years of age. The following services are available:

- Consumer directed attendant care
- Home and vehicle modification
- Personal emergency response
- Specialized medical equipment
- Transportation

For more information on the HCBS PD Waiver, see *Home and Community Based Services Brochure* online at www.ime.state.ia.us/docs/HCBSbrochure102606.pdf and also at www.ime.state.ia.us/HCBS/help_ownhome.html .

**HCBS
Children’s
Mental Health
(CMH) Waiver**

The HCBS CMH waiver provides services for children under age 18 who have been diagnosed with a serious emotional disturbance. The following services are available:

- Environmental modifications and adaptive devices
- Family and community support services
- In home family therapy
- Respite

For more information on the HCBS CMH Waiver, see the *Home and Community Based Services Brochure* online at www.ime.state.ia.us/docs/HCBSbrochure102606.pdf and also at www.ime.state.ia.us/HCBS/help_ownhome.html .

**Consumer
choices
option**

A Consumer Choices Option is an option available under the HCBS waivers, with the exception of the Children’s Mental Health Waiver. This option gives individuals control over a targeted amount of

Medicaid dollars. These dollars are used in developing an individual budget plan to meet the individual's needs by directly hiring employees and/or purchasing goods and services. The Consumer Choices Option provides more choice, control, flexibility and responsibility over services. Under this option, the individual would become the employer of the people that provide the support. They would be responsible for recruiting, hiring and firing workers and service providers. They would also be responsible for training, managing and supervising workers and service providers. This option provides flexibility by allowing individuals to purchase needed goods and services.

If an individual pursues the Consumer Choices Option, they will receive additional help upon selecting an Individual Support Broker. The Individual Support Broker will assist the person in developing the budget and recruiting employees. They will also work with a Financial Management Service for assistance managing a budget. Additional information on the Consumer Choices Option can be found online at www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html.

Section 500
Performance Management

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501 Performance Management Overview

Authority: Not applicable
Effective Date: October 16, 2012
Initial **Revision**
Replaces: 501 – January 2012

Performance management

The Iowa Department of Public Health encourages its contractors to incorporate principles of performance management within the operations of their maternal and child health programs. Performance management includes activities that ensure program goals are consistently being met in an effective and efficient manner. Performance management can focus on the functioning of an organization, a program, an individual, or the processes used to develop programs. It involves a strategic approach to building the effectiveness of an organization or program.

Performance management involves a cycle of assessment and planning \Rightarrow performance measurement \Rightarrow analysis and evaluation and \Rightarrow reporting, all of which contribute to quality improvement.

For the MCH contract agency, performance management strategies can advance its mission and goals which include:

- Assessing the health status of families at the community level to identify and prioritize community health needs and assets
- Identifying, investigating and monitoring health events
- Assessing the health system effectiveness in the community
- Informing, educating and empowering individuals, families and the public to promote positive health beliefs, attitudes and behaviors
- Advocating for public policy issues related to the maternal and child health population
- Mobilizing partnerships among groups and organizations to foster the sharing of resources, responsibilities and accountability for improving the health status of women, youth and children in the community
- Developing quality programs to meet community needs

Benefits of quality programs

Developing quality programs is central to the mission of maternal and child health programs. Quality is the result of high intention, intelligent direction and skillful execution. Quality programs position an MCH contract agency to achieve customer satisfaction, more efficient use of resources, measureable outcomes and positive impact on the community.

The benefits of quality to clients include:

- Improved services
- Improved choices
- Expectations are met or exceeded
- Employees who are client-oriented
- Friendlier and more supportive atmosphere

The benefits of quality to employees include:

- Pride in services delivered
- Job satisfaction
- Improved communication
- Streamlined work processes
- Happier clients
- Stronger client relationships

The benefits of quality to the MCH contract agency include:

- Improved/expanded services
 - Client oriented employees
 - Improved client relations
 - Improved community relations
 - Better political relations
 - Lower costs or costs contained
 - Improved funding
-

Part A: Quality Improvement

Description of quality improvement

Quality improvement in public health involves the use of a deliberate and defined improvement process which is focused on activities that are responsive to community needs and improving population health.

Examples of quality improvement models include:

- Plan-Do-Check –Act or Plan-Do-Study–Act
- Lean
- Six Sigma Kaizen
- Total Quality Management (TCM)

Quality improvement:

- Is proactive
 - Works on processes
 - Seeks to improve (culture shift)
 - Is led by staff
 - Is continuous
 - Proactively selects a process to improve
 - Exceeds expectations
-

Purpose of quality improvement activities

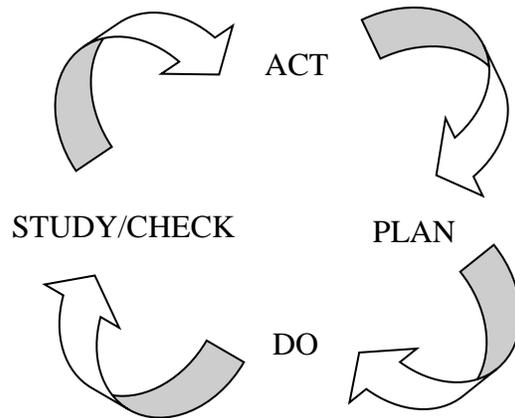
Quality improvement is a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes which achieve equity and improve the health of the community.

Quality improvement positions an MCH contract agency to achieve :

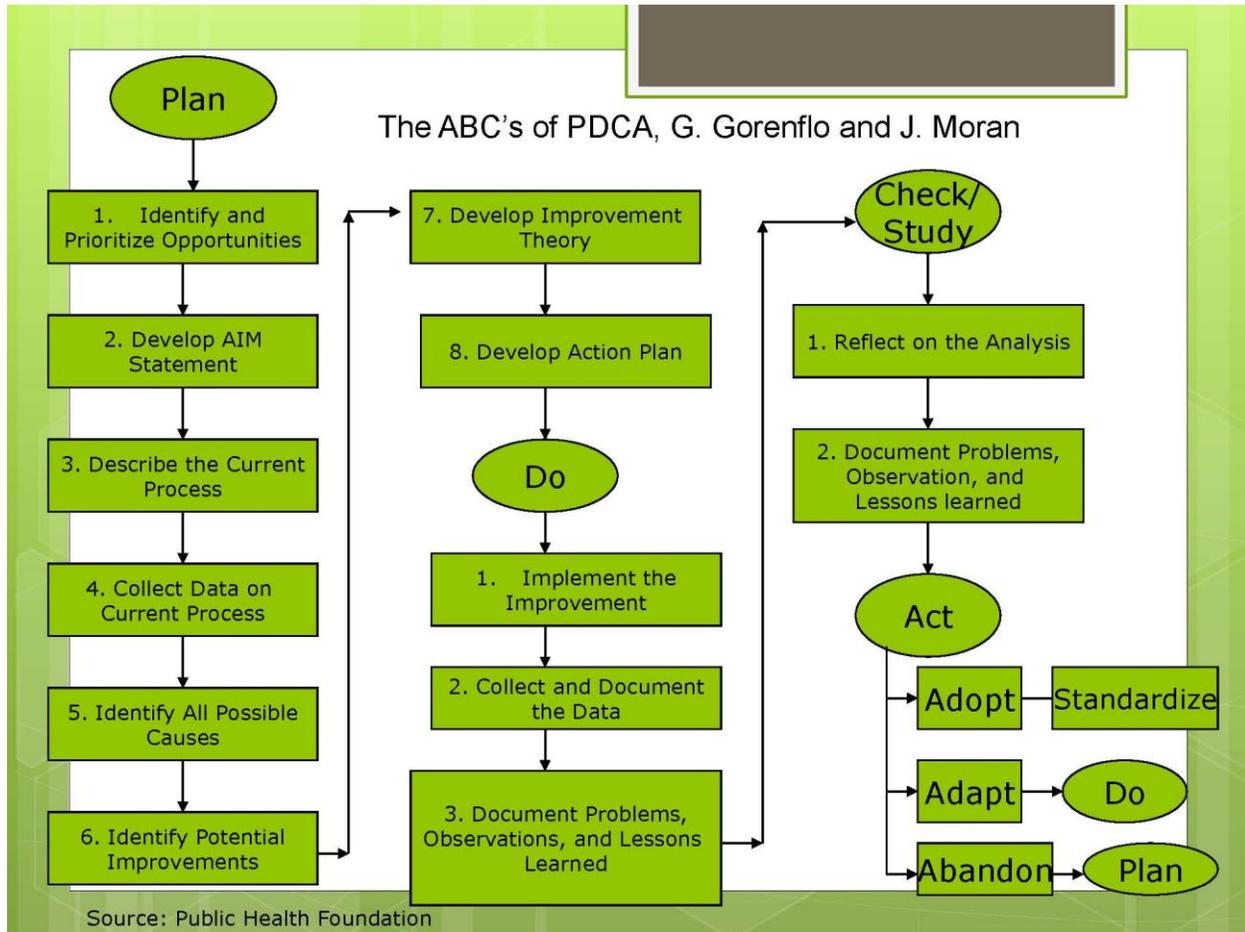
- Customer satisfaction
 - Efficient use of resources
 - Measureable outcomes
 - Community impact
-

**PDCA or
PDSA**

Plan-Do-Check-Act (or Plan-Do-Study-Act) was made popular by Dr. Deming who is considered by many to be the father of modern quality control. It was referred to by him as the “Shewhart cycle”.



The continuous improvement phase of a process is how you make a change in direction. The change is because the process output is deteriorating or customer needs have changed.



Part B: Quality Assurance

Description of quality assurance Quality assurance involves the systematic monitoring and evaluation of various aspects of an organization, program, or service to ensure that standards of quality are being met.

Quality assurance:

- Is reactive
 - Works on problems after they occur
 - Regulatory usually by state or federal law
 - Is led by management
 - Periodic look back
 - Responds to a crisis or mandate or fixed schedule
 - Meets a standard – pass/fail
-

Purpose of quality assurance activities The purpose of quality assurance activities is to verify that:

- Program requirements are being met
- Quality services are provided that comply with program guidelines
- An accurate and complete record of services is documented for each client served
- Documentation can support billings
- Documentation can withstand audits from payers, such as audits from the Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), Payment Error Rate Measurement (PERM), Iowa Department of Human Services Program and Integrity (PI) and IDPH

MCH quality assurance activities Quality assurance activities that are conducted within maternal and child health programs include the following:

- Assuring that the program adheres to expected performance measures or guidelines
- Developing and updating job descriptions for staff positions within the organization
- Assuring that staff have appropriate credentials, qualifications and competencies for job roles
- Developing and monitoring protocols for services that comply with program guidelines
- Monitoring of clinic flow for clinical services
- Conducting clinical record reviews and audits to assure general monitoring and focused review.

Performance Management

- Assuring appropriate referrals and follow-up for clients
 - Assuring medical and dental homes for clients
 - Monitoring program data, performance indicators and performance measures
 - Documenting services in CARES and WHIS correctly and completely
 - Maintaining a client-based chart for complete direct care clinical services documentation
 - Comparing billing records to documented services
 - Assessing client satisfaction with services received
-

MCH quality assurance tools

To follow are descriptions of three maternal and child health quality assurance activities for which specific tools have been developed. These include:

- Maternal and Child Health Chart Audits
 - CARES and WHIS Service Note Review
 - Administrative On-Site Review
-

Maternal and child health chart audit

Maternal Health Chart Audit

Maternal health chart audits are required for MCH contract agencies that are: 1) providers of antepartum services (medical home) with billing for global antepartum care and/or 2) providers of other direct maternal health services including any of the following services billable to Medicaid: oral care, health education, psychosocial services, social worker visit in the home, nutrition services, diabetes management, home visits by nurses, evaluation and management, pregnancy testing, vaccine administration, nursing assessments and the Medicaid prenatal risk assessment.

Chart audits are required for each clinical direct care service billed to IME that is provided by the MCH contract agency. Maternal health contract agencies are required to audit a minimum of ten maternal health records for direct care clinical services delivered over the 12 months prior to the audit. The records may be open or closed at the time of the audit. The charts should provide a representative sample of each service and the various locations of services within the MCH contract agency catchment area. A random selection process must be used to choose the charts for audit.

All billable maternal health services must be documented in WHIS. For MCH contract agencies providing direct antepartum care, the schedule of visits recommend by the American College of Obstetrics and Gynecology (ACOG) should be followed.

Child Health Chart Audit

Child health chart audits are required for MCH contract agencies providing direct medical and oral health care services to children. Chart audits are required for each clinical direct care service billed to IME that is provided by the MCH contract agency.

Child health contract agencies are required to audit a minimum of ten child health records for direct care clinical services delivered over the 12 months prior to the audit. The records may be open or closed at the time of the audit. A random selection process must be used to choose the charts for audit.

All health care services provided for children under the Child Health contract agency must be entered into CAREs. Documentation of the clinical detail for direct health care services must be maintained in a client based chart. Service logs may not be substituted for client based charts. However, a service log may be used for maintaining documentation required for transportation services.

Compliance with Iowa Administrative Code

Documentation of all maternal and child health direct care services must comply with generally accepted principles for maintaining health care records and with Medicaid requirements established in Iowa Administrative Code 641 Chapter 79.3 found at <http://www.legis.state.ia.us/ACO/IAChtml/441.htm>.

Internal and Joint Chart Audits

There are two types of maternal and child health chart audits. The requirement and process for each type is listed in the chart below.

Type	Requirement	Process
Internal Chart Audit	For contractors providing direct care clinical services, at least one self-conducted chart audit (internal chart audit) is required <u>annually</u> for each maternal health program and child health program.	The MCH contract agency's audit committee shall consist of a multidisciplinary team of at least two professionals. This team must include representatives of the disciplines providing the direct care clinical services.

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Joint Chart Audit	<u>Every two years</u> each maternal and child health contract agency is required to have a joint audit conducted by the Iowa Department of Public Health, Bureau of Family Health and Bureau of Oral and Health Delivery Systems (Oral Health Center).	The joint chart audit includes MCH contract agency staff in addition to the IDPH reviewers. When MCH contract agency personnel participate in a joint review, the agency is not required to perform a separate internal audit for that fiscal year.
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Following a chart audit, the MCH contract agency is required to submit the findings and plans for quality improvement based upon the audit (using the summary form provided by IDPH). Audit reports are submitted to IDPH by April 15 each fiscal year.

IDPH reserves the right to conduct focused or random chart audits in addition to the required chart audits.

Chart audit guidelines, tools and summaries are located on the MCH Project Management Tools website at http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.

CAReS and WHIS service note review

To improve the quality of documentation, maternal and child health contractors participate in monthly CAReS and WHIS Service Note Reviews. The purpose of these reviews is to examine the quality of service note documentation to assure quality services are provided and appropriately documented.

These quality assurance reviews serve to assure that:

- A thorough record of services provided to the client has been captured in CAReS or WHIS.
- Documentation complies with requirements established by IDPH and the Iowa Medicaid Enterprise.
- Documentation appropriately supports the services billed.

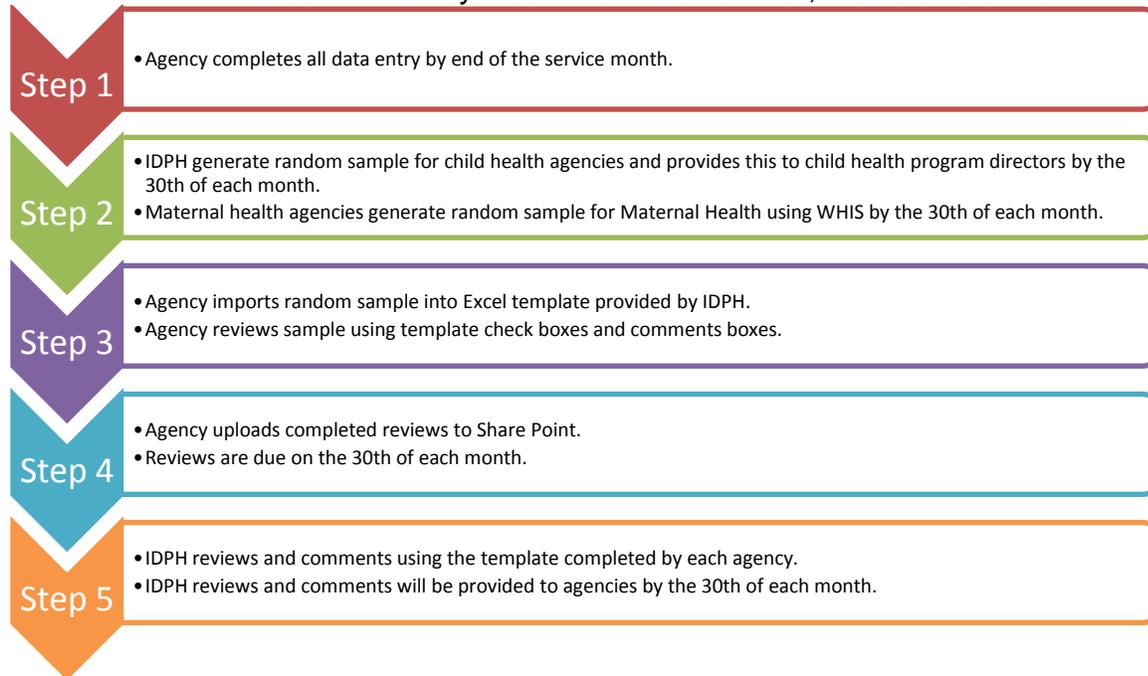
The CAReS and WHIS Service Note Review is conducted in the following manner:

- The BFH will provide each Child Health contract agency with a random sample of the agency's services. Maternal Health contract agencies will generate random samples directly from the WHIS data base.
- Each MCH contract agency will review required and best

Performance Management

practice elements for informing, care coordination, presumptive eligibility and direct care services that are entered into CARES and WHIS.

The figure below describes the basic steps and timeline for completing CARES and WHIS Service Note Reviews. Specific instructions and tools are located on the MCH Project Management Tools website at: http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.



Administrative on-site review

IDPH conducts an Administrative On-site Review of each MCH contract agency at least every other year to monitor compliance with the required policies and procedures described in Section 303. Appendix A10 of this manual contains the review checklist.

Section 600
Maternal and Child Health Services

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601 The Maternal Health Program

Authority: Iowa Administrative Code 641 IAC 75, 641 IAC 76 and 641 IAC 82; Title V - Social Security Act
Effective Date: January 19, 2012
Initial Revision
Replaces: 601 - October 2009

Overview

Overview

Maternal health programs address infrastructure building services, population-based services, enabling services and access to direct health services in accordance with Iowa Administrative Code 641 IAC 76. These services are illustrated in the MCH Pyramid of Core Public Health Services located in appendix A8 of this manual.

Core set of maternal health services

At a minimum, maternal health contract agencies are responsible for ensuring the following:

- Determining presumptive Medicaid eligibility
- Completing Medicaid Prenatal Risk Assessment (DHS form #470-2942) to determine risk status and eligibility for additional services for high- risk women
- Providing care coordination for Medicaid and non-Medicaid pregnant and postpartum women
- Providing health education
- Providing interpretation services
- Arranging transportation services
- Building local oral health infrastructure, referring maternal health clients for dental care, providing dental care coordination, providing oral health education, and providing gap-filling direct dental services when appropriate
- Developing and maintaining service delivery systems to increase access to oral health services for pregnant women
- Assessing all clients for tobacco use and referring them to tobacco cessation counseling if client is willing

Other direct care services may be provided based upon the client's needs.

Services required for high-risk pregnant women include all of the services listed above and the following:

- Development of individualized plan of care
- Psychosocial services
- Providing postpartum home visits or referring to a local nursing home visiting program that provides this service

Framework for maternal health services

The conceptual framework for community-based maternal health services is illustrated by the MCH Pyramid of Core Public Health Services. (See appendix A8 of this manual.) This framework includes the following types of services, described in more detail below.

- Infrastructure building services
- Population-based services
- Enabling services
- Direct health care services

Infrastructure building services

Infrastructure building services are activities that build the capacity of community systems to improve and maintain the health status of women and their infant(s). These services include:

- Participation in CHNA & HIP
- Collection and analysis of data
- Program planning
- Development and maintenance of partnerships
- Meeting with community partners
- Policy development
- Program evaluation
- Professional development and training
- Support of innovative initiatives
- Coordination of services
- Quality assurance
- Development of and compliance with standards

Population-based services

Population-based services provide preventive personal health services for groups of people rather than in one-on-one situations. A woman's payer source is not assessed and services for individuals are not billed. Population-based services may be provided to an entire community, county or region. Examples include:

- Immunization clinics
 - Newborn screening
 - Shaken baby syndrome prevention
 - Community classes to promote health education and prenatal classes
 - SIDS awareness
 - Oral health education
 - Community screening for maternal depression
 - Substance abuse education
 - Domestic violence education
-

Enabling services

Enabling services assist individuals and families accessing services. These services include:

- Outreach to assist women in establishing prenatal medical and dental homes
 - Assuring access to appropriate sources of health care coverage including Medicaid and presumptive eligibility for Medicaid
 - Care coordination for Medicaid and non- Medicaid eligible families
 - Assisting with access to support services such as transportation to medical/dental appointments, translation/interpreter services and case management
-

Direct health care services

Direct health care services are routine ambulatory medical and oral health care services provided for individuals. Direct health care services are to be accessed through private medical and dental providers at the local level. MCH contract agencies may provide direct care services in areas where gaps in service provision are identified. Direct care services may include, but are not limited to:

- Prenatal medical care
 - Postpartum exams
 - Family planning services
 - Immunizations
 - Pregnancy testing
 - Lab tests
 - Prenatal risk assessment
 - Nutrition counseling
 - Antepartum maternity care
 - Health education (provided one-on-one based on needs assessment)
 - Nutrition assessment and education
 - Psychosocial assessment and referral
 - Evaluation and management
 - Interpretation service
-

- Nursing assessment
- Nursing home visit
- Transportation services to medical/dental appointments
- Oral health screening
- Oral prophylaxis
- Topical fluoride varnish
- Dental sealants
- Bitewing x-rays
- Nutritional counseling for control and prevention of oral disease
- Tobacco counseling for control and prevention of oral disease
- Oral hygiene instruction

Direct medical health care services for antepartum maternity care are to be accessed through agreements established with private providers at the local level. On-site direct medical or dental care services for antepartum prenatal care which require a physician or advance practice health care provider or dental care by a dentist or hygienist are to be provided only in areas where gaps in service provision are clearly identified. Applicants proposing to provide on-site direct medical or dental care services must demonstrate that provider availability and other barriers to accessing care exist.

Direct care services provided by a maternal health contract agency must meet service delivery requirements and documentation requirements, irrespective of the source of funding for the services. Direct care services, regardless of the source of funds, are subject to the requirements within the program. If the MH contract agency or its subcontractors deliver direct care services, the MH contract agency may not claim exemption to these requirements based upon payment source.

**Maternal
Health
Screening
Center
provider**

Maternal health contract agencies are responsible for delivery of direct health medical or enhanced services as detailed in the Medicaid Provider Manual for Maternal Health Centers. Agencies apply to the Iowa Department of Human Services (DHS) to become designated as Medicaid Maternal Health Centers. With this designation, the MH contract agency qualifies for Medicaid to serve as a payer for direct health care (medical and dental) services for prenatal and postpartum Medicaid eligible women.

Enhanced services may be provided by licensed dietitians, bachelor-degreed social workers, physicians and nurses, employed by or on contract with the MH contract agency.

Care coordination services are provided to all pregnant women.

Additional services are provided to high-risk pregnant women as determined by the Medicaid prenatal risk assessment tool.

Maternal health contract agencies are required to annually determine the cost for providing services for the maternal health program. MH contract agencies are required to bill Medicaid the actual costs for services.

The Maternal Health Services Summary contains a summary of maternal health services, documentation requirements, precautions and billing codes. The document is posted on the MCH Project Management Tools website at http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.

Maternal health program coordinator

Persons hired to perform activities of a maternal health program coordinator are required to have a minimum of six months experience in health or human services. Experience in community or public health is preferred. They are also required to possess at least one of the following:

- Bachelor's degree in a health or human services field
- Current license as a registered nurse (RN) with a bachelor's degree in any field
- Current license as an advanced registered nurse practitioner (ARNP)

An individual who has served in the capacity of program coordinator prior to October 1, 1995, will be considered qualified to continue in that position. The program coordinator is responsible to and carries out activities as directed by the executive director and project director.

Maternal health electronic record and data system

Maternal health contract agencies utilize the Women's Health Information System (WHIS) to collect client information, document a client record and develop a plan of care to address the client's needs. Data files exported to IDPH on a monthly basis are analyzed and used to meet federal reporting requirements, for program planning and evaluation, and quality assurance. All maternal health client records (hard copy and/or electronic) are the property of IDPH. For specific information, reference the Women's Health Information System Manual, available from the IDPH website at www.idph.state.ia.us/hpcdp/common/pdf/family_health/womans_health_system_manual.pdf

Quality assurance plan

Maternal health contract agencies are required to develop and implement a plan for quality assurance. Program activities are expected to support the National Performance Measures/State Performance Measures/Outcome Measures (NPM/SPM/OM) as published in Iowa's MCH Title V State Plan. (See appendix A11 of this manual.) Additional quality assurance activities include, but are not limited to:

- Internal and external chart audit of direct care services
- Review of WHIS service notes
- Comparison of billing records with WHIS and/or client chart records
- Review of WHIS reports
- Clinical services monitoring
- Client satisfaction surveys
- Staff development on quality improvement initiatives

See section 500 of this manual for more information on quality assurance/quality improvement.

Cost analysis

Each year maternal health contract agencies are required to determine the cost for services provided. The MH contract agency is required to bill Medicaid, IDPH and other payers the actual cost of services. The MCH Cost Analysis is completed using IDPH approved methodology and forms. The MCH Cost Analysis and Transportation Plan are submitted to IDPH and maintained on file by the MH contract agency. Policy 402 of this manual contains additional cost analysis information.

Guidelines and forms are found on the MCH Project Management Tools website at www.idph.state.ia.us/hpcdp/mch_costing.asp.

Reimbursement for services

Through an agreement between the Iowa Department of Human Services and IDPH, maternal health contract agencies receive reimbursement from IDPH for their cost (up to an established maximum) for outreach (presumptive eligibility) and care coordination services for Medicaid clients. In addition, IDPH reimburses the MH contract agency's cost (up to the established maximum) for care coordination services for non-Medicaid clients. These services are reimbursed on a fee-for-service basis.

Maternal health contract agencies bill the Iowa Medicaid Enterprise (IME) for direct health care services for Medicaid members. The IME reimburses the MH contract agency's cost of service (up to an established maximum). Reimbursement is on a fee-for-service

basis. Title V grant funds are the payer of last resort.

Public-private partnerships

Active public-private partnerships are essential for assuring that women have access to preventive health services. Maternal health contract agencies are encouraged to advance partnerships with local practitioners and other providers in coordinating services for women. Local practitioners and maternal health contract agencies need to work cooperatively to best meet the needs of women and their families. Maternal health program coordinators are encouraged to meet with practitioners and their staff to dialog about effective working relationships.

Community Health Needs Assessment & Health Improvement Plan (CHNA & HIP)

Local boards of health are required to conduct a Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP) every five years. Maternal health contract agencies have an important role in advancing community level recognition of the health needs of pregnant women. Participation in the needs assessment process provides the opportunity to advocate for the needs of women in the counties served. Each maternal health contract agency is expected to participate in assessing the indicators that affect the maternal health population in each of the counties in the service area. Data collected through the Women's Health Information System (WHIS) and other resources can help communities identify and prioritize their community health needs. Find more information on the CHNA & HIP at www.idph.state.ia.us/chnahip/default.asp.

Presumptive Medicaid eligibility

Presumptive Medicaid eligibility allows pregnant women to receive Medicaid coverage for prenatal care while a formal Medicaid eligibility determination is being made by the Iowa Department of Human Services. MH contract agencies must follow the guidance for service as printed in the DHS All Providers Manual, Chapter II, Member Eligibility, at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/all-ii.pdf

Title XIX Medicaid coverage and limitations

MH contract agencies must follow the guidance for services as printed in the Medicaid Provider Manual for Maternal Health Centers available from the DHS website at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/maternhcc.pdf

The manual contains information about Medicaid services and

coverage for maternal health clients. The *Coverages and Limitations* section of the Medicaid Provider Manual for Maternal Health Centers specifically addresses enhanced services for low-risk and high-risk maternal health clients.

Billable expenses

Billable codes for enhanced services are detailed in the *Coverages and Limitations* section of the Medicaid Provider Manual at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/maternhc.pdf

Billable codes for maternal oral health services are detailed in section 700 of this manual.

Reimbursement rates are as noted in the most current Medicaid Fee Schedule. MH contract agencies must bill their documented costs based on cost analysis, not the stated reimbursement rate.

Obstetrical and Newborn Indigent Patient Care Program

Services for this program are specified in Iowa Administrative Code 641 IAC 75. Chapter 75 provides for assistance to pregnant legal residents of Iowa currently living in any county except Clinton, Cedar, Scott, Muscatine, Louisa, Washington, Iowa, Johnson or Keokuk. Eligibility requirements besides county of residence are Title XIX denial and income above 185 percent of poverty level but less than 300 percent of the poverty level. Women may be responsible for a spend-down amount if income is above 200 percent of poverty level. Reimbursement for services is at Medicaid rates. Services covered include antepartum care, delivery, newborn hospital care and enhanced services.

Application procedure

The maternal health (MH) program coordinator at the maternal health contract agency reviews eligibility for the OB indigent program with the potential client. The MH program coordinator and the client then complete and sign an application form and fax the form to the Iowa Department of Public Health (IDPH), marked to the attention of the state maternal health consultant. The state maternal health consultant reviews the application and determines enrollment based on eligibility and availability of funds. Funds are encumbered once the client is "enrolled." It is the responsibility of the local MH program coordinator to notify the state maternal health consultant of any changes in eligibility.

Maternal Health Services and Program Components

Outreach – presumptive eligibility determination

Maternal health contract agencies provide education about presumptive eligibility for Medicaid and assist pregnant women in completing the Health Services Application form 470-2927 or the Spanish Health Services Application form 470-2927(S). This allows the qualified provider to make a presumptive eligibility determination. Eligible clients must be pregnant and have an Iowa address. US citizenship is not a requirement.

Each MH contract agency must have a memorandum of understanding with DHS prior to providing this service and then maintain a qualified provider status from DHS.

Prenatal risk assessment

After obtaining consent from the client to participate in the maternal health program, the MH contract agency should determine her prenatal risk by using form 470-2942, *Medicaid Prenatal Risk Assessment*. The form is incorporated in the WHIS database and available online at

www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/470-2942.pdf.

IDPH and DHS jointly developed the *Medicaid Prenatal Risk Assessment* to help the clinician determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care. A total score of 10 meets the criteria for high risk on this assessment.

When the assessment indicates a low-risk pregnancy, the MH contract agency should complete a second determination at approximately 28 weeks of care or when an increase in the pregnant woman's risk status is indicated. When a high-risk pregnancy is identified, enhanced services outlined in the Maternal Health Services Manual may be provided. The MH contract agency should keep a copy of the assessment in the patient's medical record.

Care coordination services

Care coordination is the process of linking both Medicaid and non-Medicaid women to needed services. Billable care coordination services must include linkage to medical, dental, mental health and/or other Medicaid covered services/programs. Care coordination is provided via phone or face-to-face contacts with the family, including home visits. Care coordination activities include:

- Contacting families to remind them of periodic medical and dental exams
- Assisting families to schedule appointments as needed (external to the MH contract agency)
- Reminding families of appointments
- Following-up with families on missed appointments
- Assisting families when referral for further medical, dental and/or mental health services are indicated
- Arranging transportation to medical/dental/mental health appointments
- Arranging medical/dental/mental health interpretation services
- Conducting follow-up to determine if services have been received

Note: Care coordination provided in conjunction with a direct care service is considered part of the direct care and may not be billed separately.

Transportation services

Under the Maternal Health Services program, Medicaid provides direct payment to maternal health contract agencies for local (in-town) transportation services to take pregnant/postpartum women to Medicaid providers for medical, dental or mental health appointments. Maternal health contract agencies must submit a transportation plan to IDPH each year that identifies the modes of transportation to be used (bus, taxi, wheelchair van, volunteer and/or non-profit transportation system) and their costs.

The Iowa Department of Human Services also contracts with Transportation Management Services (TMS) to handle arranging and paying for in-town and out-of-town transportation services for Medicaid members. For maternal health contract agencies, TMS can be especially helpful in arranging for out-of-town transportation services for medical, dental or mental health appointments. Contact TMS at 1-866-572-7662 at least 72 hours in advance of the appointment to make arrangements.

Health education

Health education services are provided by a registered nurse and include:

- Importance of continued prenatal care
- Normal changes of pregnancy:
 - Maternal changes
 - Fetal changes
- Self-care during pregnancy
- Comfort measures during pregnancy
- Danger signs of pregnancy
- Labor and delivery:

- Normal process of labor
 - Signs of labor
 - Coping skills
 - Danger signs
 - Management of normal labor
 - Preparation for baby:
 - Feeding
 - Equipment
 - Clothing
 - Education on the use of over-the-counter drugs
 - Education about HIV prevention
 - Other education needs as identified by MH contract agency staff or primary care provider
-

Oral health direct care services

Oral health direct care services may be provided within the scope of practice defined by Iowa Code for dental hygienists, registered nurses, advanced registered nurse practitioners and physician assistants. Services include:

- Oral screening – screenings should be considered for all women, especially those who have indicated they have problems with their teeth and gums or if a health history indicated that the woman is at risk for tooth decay or gum disease. An oral screening includes:
 - Medical/dental history
 - Soft and hard tissue evaluation
 - Oral health education
 - Dental referral – based on findings from the oral screening. The provider should determine a care plan for preventive services and referral to a dentist. At a minimum, a client should visit the dentist once during pregnancy.
- Preventive services – The following services may be provided to prenatal and postpartum clients:
 - Fluoride varnish
 - Prophylaxis
 - Radiographs
 - Dental sealants

Additional information is available in section 700 of this manual.

Nursing assessment

Nursing assessment and evaluation may be provided for a known medical condition such as preterm labor, pre-eclampsia and urinary tract infection. The service is provided by a registered nurse in the office setting, not as part of a home visit.

Nutrition services

A licensed dietitian may provide nutrition services. Nutrition assessment and counseling may include:

- Initial assessment of nutritional risk
 - Discussion of breastfeeding
 - At least one follow-up nutritional assessment
 - Development of an individualized nutritional care plan
 - Referral to food assistance, as indicated
 - Nutritional interventions may include:
 - Nutritional requirements of pregnancy
 - Recommended dietary allowances for pregnancy
 - Appropriate weight gain
 - Vitamin and iron supplements
 - Information to make an informed infant feeding decision
 - Education to prepare for the proposed feeding method and support services available for the mother
 - Infant nutritional needs and feeding practices
-

Psychosocial services

Psychosocial assessment and counseling will include:

- A psychosocial needs assessment including a profile of the mother's:
 - Demographic factors
 - Mental and physical health history and concerns
 - Adjustment to pregnancy and future parenting
 - Environmental needs
- A profile of the mother's family composition, patterns of functioning and support system
- An assessment-based plan of care
- Risk tracking
- Counseling and anticipatory guidance as appropriate
- Referral and follow-up services

The social worker may provide a home visit if the need is identified.

Awareness of intimate partner violence and reproductive coercion

Maternal health contract agencies are encouraged to adopt the *Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion* as best practice for education, referral and training. These guidelines were produced by Futures Without Violence and were funded through the Administration for Children and Families and the Office on Women's Health, U.S. Department of Health and Human Services. The document is available on the federal website at

www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf

Intimate partner violence is a pattern of assaultive and coercive behaviors in same sex or heterosexual relationships, that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was or wishes to be involved in an intimate or dating relationship with an adult or adolescent and are aimed at establishing control by one partner over the other.

Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship related to reproductive health. Examples of reproductive coercion include:

- Explicit attempts to impregnate a female partner against her will
- Controlling the outcomes of a pregnancy
- Coercing a partner to engage in unwanted sexual acts
- Forced omission of condom use during intercourse
- Threats or acts of violence if a person doesn't agree to have sex
- Intentionally exposing a partner to a sexually-transmitted illness

MH contract agencies are encouraged to provide all clients presenting for family planning or maternal health services and, when appropriate, child health services with verbal or written education on intimate partner violence and reproductive coercion and human trafficking.

MH contract agencies should have written protocols in place in the event that intimate partner violence or reproductive coercion is suspected or divulged. The protocols should include the following:

- Discuss the suspicion with the provider's supervisor
- Call the Human Trafficking Hotline at 1-888-373-7888
- Follow mandatory reporting protocols for victims of child abuse
- Follow existing protocols for victims of domestic violence or crime
- Provide options for the victim
- Explain reporting obligations

Authorities may only be notified with permission from the victim. To ensure permission is given, the call should be made in the presence of the victim.

Training on intimate partner violence and reproductive coercion is encouraged for all clinic staff members that have contact with clients. Training by staff from domestic violence and sexual assault programs is recommended.

Appendix A19 of this manual contains resources for MCH contract

agencies regarding intimate partner violence and reproductive coercion.

Awareness of human trafficking

Maternal health contract agencies are encouraged to utilize the resources available at the Polaris Project for a World without Slavery regarding the identification of human trafficking victims. The resources are available on the Polaris Project website at www.polarisproject.org/index.php.

Human trafficking is a form of modern-day slavery where people profit from the control and exploitation of others. Human trafficking occurs in two forms:

- Sex trafficking: the recruitment, harboring, transportation, provision or obtaining of a person for the purpose of a commercial sex act, in which a commercial sex act is induced by force, fraud or coercion, or in which the person forced to perform such an act is under the age of 18 years
- Labor trafficking: the recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery

Victims of human trafficking are not limited by age, gender, race or nationality. Victims include adults and minors, males and females, individuals of all races and citizens of all countries.

Appendix A19 of this manual contains resources for MCH contract agencies regarding human trafficking.

Nursing visits in the home

A nursing visit may be provided in the home when a medical need is identified during the pregnancy or after delivery. A registered nurse may provide a postpartum home visit within two weeks of the client's discharge from the hospital or refer to a local home visiting program that provides this service. The American Academy of Pediatrics recommends that mothers and infants discharged within 48 hours of the birth should receive a home visit within 48 hours of discharge. The visit should include:

- An assessment of the mother's physical and mental health
- Family planning
- Parenting skills
- Infant's health
- Infant care
- Community resources and referrals if indicated

Some mothers with high medical risk may benefit from multiple postpartum nursing visits in the home. The limit for Medicaid-reimbursed postpartum home visits is 10 units (10 hours) during a period of 200 days after delivery.

If the mother refuses a home visit, follow-up care should be offered through a clinic visit or a care coordination phone call. If the delivery was covered by Medicaid, the mother is automatically eligible for enrollment in the Iowa Family Planning Network, an expanded Medicaid program that provides free or reduced-fee birth control options for postpartum women.

Interpretation services

Medicaid provides direct payment for interpretation services provided in conjunction with a Medicaid-covered service (presumptive eligibility determination, care coordination, medical, dental or mental health services). Interpretation services include sign language or oral interpretive services and telephonic oral interpretive services.

Billable interpretation services are provided by interpreters who provide only interpretive services. These interpreters must be employed or contracted by the maternal health contract agency and may not have shared job roles within the agency other than providing interpretation services. Medical staff that are bilingual are reimbursed for their medical services but not for any interpretation that they may provide.

Interpreter services for insured or underinsured clients would be covered through Title V maternal health funds.

It is the responsibility of the maternal health contract agency to determine the interpreter's competency. Sign language interpreters must be licensed pursuant to Iowa Administrative Code 645 Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org).

Documentation of services

All enabling services and direct health care services provided by the maternal health contract agency must be entered into the Women's Health Information System (WHIS) in the service detail section. The complete service notes for direct care services may be done in a client record. The WHIS User Manual may be found on the IDPH website at www.idph.state.ia.us/hpcdp/common/pdf/family_health/womans_health_system_manual.pdf

Documentation requirements for care coordination services include:

- Name of client
- Date of service
- Place of service (if not agency main address)
- Time in and time out including a.m. and p.m. – for care coordination and any other service billed based upon timed units
- Name of person to whom services were provided
- Scope of the service – issues addressed, information from the family, outcomes, referrals, refusal of services, etc.
- First and last name of provider and credentials (if applicable)
- Signature / signature log

Documentation for interpretation services must include:

- Name of client
- Date of service
- Name of interpreter and/or interpreter's company
- Time in and time out including a.m. and p.m.
- Invoice of cost

Documentation for transportation services must include:

- Name of client
- Date of service
- Who provided the service
- Address where client was picked up
- Destination (medical/dental provider's name and address)
- Invoice of cost
- Mileage if transportation is paid per mile

Documentation of antepartum medical direct care must include:

- Name of client
- Date of service
- Problems or needs identified
- Follow-up referrals
- System assessments
- Plan of care including referrals made / action taken
- Patient education provided
- First and last name of provider and credentials
- Signature of the medical professional

For direct care services provided, a client-based chart must also be maintained for the complete clinical record. Documentation must comply with generally accepted principles for maintaining health records and with requirements established by DHS in Iowa Administrative Code 441 Chapter 79.3 found at

www.legis.state.ia.us/ACO/IAChtml/441.htm.

All health client records (hard copy and/or electronic) are property of IDPH.

See the Maternal Health Services Summary for a summary of maternal health services, documentation requirements, cautions and billing codes. The summary is posted on the MCH Project Management Tools website at

http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826.



602 The Child Health Program

Authority: Iowa Administrative Code 641 IAC 76 (135); Title V Social Security Act
Effective Date: January 19, 2012
Initial Revision
Replaces: 602—October 2009

Overview

Purpose and goals

The purpose of the Title V child health program is to promote the development of local systems of health care for children from birth to age 22. Child health services are designed to be community-based, family-centered, comprehensive, flexible, collaborative, coordinated, and culturally and developmentally appropriate.

The goals of the child health program are to:

- Promote the health of infants and children by ensuring access to quality preventive health services, especially for low-income families or families with limited access to health services
- Reduce infant mortality and the incidence of preventable diseases and disabling conditions
- Increase the number of children fully immunized against disease
- Promote the development of community-based systems of medical and oral health care for infants, children, youth and their families

Core set of child health services

At a minimum, child health (CH) programs are responsible for ensuring the following:

- Informing/re-informing services for families of newly Medicaid eligible children
- Care coordination* for both Medicaid and non-Medicaid enrolled children to assure access to well child services, ideally through medical and dental homes
- Transportation services
- Interpretation services
- Early ACCESS service coordination for identified population
- **hawk-i** Outreach, including presumptive eligibility determinations for children
- Oral health services under the I-Smile™ program

**Care coordination* services include medical care coordination, dental care coordination and capacity to provide home visits for care coordination. Surveillance for children's healthy mental development is strongly encouraged.

CH contract agencies are expected to advance Child Care Nurse Consultant (CCNC) services under Healthy Child Care Iowa (HCCI).

CH contract agencies are expected to assure availability of direct care services. Direct care services such as developmental testing, immunizations and blood lead testing may be provided by the CH contract agency based upon community needs.

Framework for child health services

The conceptual framework for community-based child health services is illustrated by the MCH Pyramid of Core Public Health Services. (See appendix A8 of this manual.) This framework includes the following types of services, described in more detail below:

- Infrastructure building services
- Population-based services
- Enabling services
- Direct health care services

Infrastructure building services

Infrastructure building services are activities that support the development and maintenance of comprehensive health service systems. Examples include:

- Assessment of community needs and assets
- Data collection and analysis
- Program planning
- Policy development
- Establishment of community linkages including primary care providers
- Facilitation of interagency coordination
- Development and monitoring of protocols
- Cost analysis
- Program evaluation
- Quality assurance and quality improvement initiatives
- Professional development and training
- Support for innovative initiatives

Population-based

Population-based services provide preventive personal health services for groups of children rather than in one-on-one situations. A child's

services payer source is not assessed and services for individuals are not billed. Population-based services may be provided to an entire community, county or region. Examples include:

- Newborn screening services
 - Immunization clinics
 - Lead testing clinics
 - Community screening for maternal depression
 - Oral screenings for the school screening requirement
 - Community screening for substance abuse and/or domestic violence
 - Breastfeeding promotion and support
 - Health education for groups of individuals
 - SIDS awareness
 - Prenatal health education classes
 - Injury prevention education
 - Child care and school health education
 - Other public health awareness campaigns
-

Enabling services Enabling services assist families to gain access to needed services. Enabling services include:

- Outreach for health care coverage including Medicaid and *hawk-i*
 - Presumptive eligibility determinations for children
 - Assisting families in establishing medical and dental homes
 - Informing services for newly Medicaid enrolled children
 - Care coordination services for Medicaid and non-Medicaid enrolled children, including home visits for care coordination
 - Reminding families that periodic screens are due
 - Assisting families to access support services including transportation to medical/dental/mental health providers and interpreter services for medical/dental/mental health services
 - Service coordination for the target population in the Early ACCESS program (children with lead levels of 20 µg/dL or greater)
-

Direct health care services Direct health care services include routine, ambulatory well-child medical and oral health care. Direct care services include:

- Comprehensive well child screening exams (initial or periodic)
 - Immunization administration and related counseling
 - Blood lead testing
 - Other lab tests (urinalysis, hematocrit, hemoglobin)
 - Visual acuity testing
 - Speech audiometry (hearing)
 - Developmental testing
 - Nutrition counseling
-

- Nursing assessment/evaluation
- Home visit for nursing services
- Home visit for social work services
- Evaluation and management
- Oral health direct care services include:
 - Oral health screenings (initial or periodic)
 - Oral prophylaxis
 - Dental sealant applications
 - Bitewing radiographs
 - Oral evaluation and counseling with primary caregiver (children under age 3)
 - Topical fluoride varnish
 - Nutritional counseling for the control and prevention of oral disease
 - Oral hygiene instruction

Ideally, direct health care services are to be accessed through agreements established with private medical and dental providers at the local level. However, preventive direct health care services may be supported by CH programs in areas where gaps in service provision are identified. CH contract agencies providing full well child exams must demonstrate that provider availability or other barriers exist.

Whether providing the full well child screen or selected gap-filling direct care services, child health programs are responsible for assuring that the children they serve receive regular well child exams. As a child health program, providing selected gap-filling services does not preclude the CH contract agency's responsibility for assuring the well child exams for a child.

Direct care services provided by a child health contract agency must comply with the policies, procedures, rules and regulations found within this manual, regardless of their source of funding. The CH contract agency and/or its subcontractors may not claim exemption to IDPH policy and procedure requirements based upon the payment source for the services provided.

Direct care and FQHCs / RHCs

Child health contract agencies that are Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs) must emphasize infrastructure building and enabling activities that involve collaboration with medical and dental practices within the service area. Efforts must be made to encourage and recruit private practices within the service area to provide services for low-income children, both uninsured and underinsured, and those enrolled in Medicaid.

For CH contract agencies that are FQHCs or RHCs, Child Health (including OH), grant funds and/or associated program income **may not** be used to support *direct health care services* provided by the FQHC or RHC. These Child Health programs are encouraged to refer clients to the clinical operations (direct care arm) of FQHC or RHC clinics, as well as to private medical and dental providers, for direct care services. Revenue generated by these Child Health and Oral Health programs **must** be used to enhance the respective programs, e.g., informing, care coordination, oral screenings and local transportation services.

Medicaid Screening Center provider

Upon approval of the Title V application to IDPH, child health programs must apply for and receive approval as a Medicaid Screening Center. Medicaid serves as a payer for direct health care services for Medicaid enrolled children from birth to age 21. Medicaid's EPSDT *Care for Kids* program provides the model of services for **all children** served through child health programs.

Guidelines for providing EPSDT direct care services are found within Medicaid's Screening Center Manual at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf. See section 608 EPSDT *Care for Kids* Program for more information.

Child health program coordinator

The child health contract agency must designate a child health program coordinator to facilitate program development and implementation. The child health (CH) program coordinator is responsible for activities as directed by the executive director and MCH project director.

Persons hired to perform activities of a CH program coordinator are required to have a minimum of six months experience in health or human services. Experience in community or public health is preferred. They are also required to possess at least one of the following:

- Bachelor's degree in a health or human services field
- Current license as a registered nurse (RN) with a bachelor's degree in any field
- Current license as an advanced registered nurse practitioner (ARNP)

The CH program coordinator may either serve in a dual role as the EPSDT coordinator or may delegate these duties to qualified staff. If different individuals are assigned to the two positions, the EPSDT

coordinator will report to the CH program coordinator.

Quality assurance plan

Child health programs develop and implement a plan for quality assurance. Program activities are expected to support the National Performance Measures/State Performance Measures/Outcome Measures (NPM/SPM/OM) as published in Iowa's MCH Title V State Plan. (See appendix A11 of this manual.) Additional quality assurance activities include, but are not limited to:

- Internal and external chart audit of direct care services
- CARES service note review
- Comparison of billing records with CARES and/or client records
- Review of CARES reports
- Clinical services monitoring
- Client satisfaction surveys
- Staff development on quality improvement initiatives

See section 500 of this manual for more information on quality assurance and quality improvement.

Cost analysis

Each year child health programs are required to determine the cost for services provided. The child health program is required to bill Medicaid, IDPH and other payers the actual cost of services. The required MCH Cost Analysis is completed using IDPH approved methodology and forms. The MCH Cost Analysis and Transportation Plan are submitted to IDPH and maintained on file by the CH contract agency. Policy 402 of this manual contains additional cost analysis information.

Guidelines and forms are found on the MCH Project Management Tools website www.idph.state.ia.us/hpcdp/mch_costing.asp

Reimbursement for services

Child health programs receive reimbursement from IDPH for their cost (up to an established maximum) for presumptive eligibility, informing and care coordination services. CH contract agencies receive reimbursement for care coordination services provided for both Medicaid enrolled and non-Medicaid clients. These services are reimbursed on a fee-for-service basis.

Child health programs bill the Iowa Medicaid Enterprise (IME) for direct health care services for Medicaid members. The IME reimburses the child health program's cost of service (up to an established maximum). Reimbursement is on a fee-for-service basis. Title V grant funds are the payer of last resort.

Public-private partnerships

Active public-private partnerships are essential for assuring that children access preventive health services. Child health programs are encouraged to advance partnerships with local practitioners and other providers in coordinating services for children. Local practitioners and child health programs need to work cooperatively to best meet the needs of Iowa's children and families. Child health program coordinators are encouraged to meet with practitioners and their staff to dialog about effective working relationships.

Community Health Needs Assessment & Health Improvement Plan (CHNA & HIP)

Local boards of health are required to conduct a Community Health Needs Assessment and develop a Health Improvement Plan (CHNA & HIP) every five years. Child health programs have an important role in advancing community level recognition of the health needs of infants, toddlers, children and youth. Participation in the needs assessment process provides the opportunity to advocate for the needs of children in the counties served.

Each child health contract agency is expected to participate in assessing the indicators that affect the child health population in each of the counties in their service area. Data collected through the Child and Adolescent Reporting System (CAREs) and other resources can help communities identify and prioritize their community health needs. Find more information on the CHNA & HIP at www.idph.state.ia.us/chnahip/default.asp.

Child Health Services and Program Components

Informing services

Child health programs are responsible for providing informing services for Medicaid enrolled children and care coordination services for both Medicaid and non-Medicaid clients. (See the EPSDT Care for Kids Informing and Care Coordination Handbook at www.idph.state.ia.us/hpcdp/common/pdf/epsdt_handbook.pdf)

Informing is the act of advising families of newly Medicaid eligible children about the services available within the EPSDT Care for Kids program. Informing services include:

- Explaining the benefits of preventive medical and dental care
- Encouraging families to develop permanent provider relationships (medical and dental homes)
- Explaining the screening services available under the EPSDT Care for Kids program
- Explaining care coordination services that can provide assistance with arranging medical, dental and mental health appointments; transportation services to medical, dental and mental health appointments; and medical, dental, mental health interpretation services
- Explaining what to expect when a child receives a medical or dental screen
- Providing information as to where community resources are located and how to obtain them
- Assuring that families have freedom of choice in selection of primary care providers

Child health programs are required to maintain participation rates for EPSDT health screening services at a minimum of 80 percent for each county within their service delivery area. See CMS 416 Participation Rate Data on the IDPH EPSDT website at www.idph.state.ia.us/hpcdp/epsdt_providers.asp.

Care coordination services

Care coordination is the process of linking both Medicaid and non-Medicaid children to needed services. Billable care coordination services must include linkage to medical, dental, mental health and/or other Medicaid-covered services/programs. Care coordination is provided via phone or face-to-face contacts with the family, including home visits. Care coordination activities include:

- Contacting families to remind them of periodic medical and dental exams
- Assisting families to schedule appointments as needed (external to the CH contract agency)
- Reminding families of appointments

- Working with the child's medical and dental private practitioners to coordinate care
- Following up with families on missed appointments
- Assisting families when referral for further medical, dental and/or mental health services are indicated
- Arranging transportation to medical/dental/mental health appointments
- Arranging interpretation services
- Conducting follow-up to determine if services have been received

Note: Care coordination provided in conjunction with a direct care service is considered part of the direct care and cannot be billed separately. Additionally, care coordination provided at the time of an informing service is considered part of the informing process.

Transportation services

Under the EPSDT program, Medicaid provides direct payment to child health programs for **local (in-town)** transportation services to take children to Medicaid providers for medical, dental or mental health appointments. Child health programs submit a transportation plan to IDPH each year that identifies the modes of transportation to be used (bus, taxi, wheelchair van, volunteer and/or non-profit transportation system) and their costs.

The Iowa Department of Human Services also contracts with Transportation Management Services (TMS) to handle arranging and paying for in-town and out-of-town transportation services for Medicaid members. For child health programs, TMS can be especially helpful in arranging for out-of-town transportation services for medical, dental or mental health appointments. Contact TMS at 1-866-572-7662 at least 72 hours in advance of the appointment to make arrangements.

Interpretation services

Under the EPSDT program, Medicaid provides direct payment for interpretation services provided in conjunction with another Medicaid covered service (informing, care coordination, medical, dental or mental health services). Interpretation services include sign language or oral interpretive services and telephonic oral interpretive services.

Billable interpretation services are provided by interpreters who provide **only** interpretive services. These interpreters must be employed or contracted by the child health contract agency and may not have shared job roles within the agency other than providing interpretation services. Medical staff that are bilingual are reimbursed for their medical services but not for any interpretation that they may provide.

Interpreter services for insured or underinsured clients would be covered through Title V child health funds.

It is the responsibility of the child health contract agency to determine the interpreter's competency. Sign language interpreters must be licensed pursuant to Iowa Administrative Code 645 Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org).

Immunizations MCH contract agencies are expected to support the goals of the IDPH immunization program to protect children and adults from vaccine preventable diseases. MCH contract agencies providing immunizations are required to use the Immunization Registry Information System (IRIS) for entry of immunizations. MCH contract agencies also coordinate services with other immunization providers in the counties served. Programs follow the guidelines for childhood immunizations established by the CDC's Advisory Committee on Immunization Practices (ACIP) at www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable.

Program emphasis is placed on the following activities:

- Providing barrier-free access to immunization services. This includes accepting clients with no appointments (walk-ins) and/or providing immunizations in conjunction with other services such as WIC or blood lead testing.
 - Conducting reminder/recall to ensure that patients return for additional immunizations on time
 - Offering several options to receive vaccine
 - Providing on-going immunization education and information to the public
-

Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) Child health programs are required to develop or maintain linkages with established Healthy Homes and Lead Poisoning Prevention Programs (HHLPPP) within their service area. Child health programs may choose to explore the development of a HHLPPP in areas of the state where they *do not* exist. The child health contract agency may be able to submit application to the IDPH HHLPPP for funding. For more information, CH contract agencies may contact the IDPH Healthy Homes and Lead Poisoning Prevention Program at (800) 972-2026. Alternately, child health programs may choose to use child health grant funds to develop the capacity for the establishment of a local HHLPPP.

Note that the IDPH Bureau of Lead Poisoning Prevention provides follow-up services in areas of the state where there is no HHLPPP.

Additional information about the Healthy Homes and Lead Poisoning Prevention Program is located in policy 612 of this manual.

***hawk-i*
outreach**

Child health contract agencies are responsible for conducting outreach for Medicaid and the Healthy and Well Kids in Iowa (***hawk-i***) programs in their service area. Each CH contract agency designates a local ***hawk-i*** outreach coordinator. The ***hawk-i*** outreach coordinator is the single point of contact for ongoing outreach activities. They complete quarterly reports on outreach activities and attend required ***hawk-i*** Outreach Taskforce meetings. Each CH contract agency is responsible to assure that ***hawk-i*** outreach activities, including informational materials, are consistent with Iowa Department of Human Services approved activities and materials. Locally developed informational materials must be approved in advance by the Iowa Department of Human Services.

hawk-i outreach programs facilitate the provision of presumptive eligibility determination services for children. They also promote collaboration with stakeholders with a focus on outreach efforts in four specific areas:

- Schools
- Faith-based organizations
- Health care/medical providers
- Special populations, including racial and ethnic minority groups

Three steps to effective ***hawk-i*** outreach include:

1. Motivating individuals to take action to find out more about the programs and to either participate or spread the word
2. Assisting families in accessing the benefits of the programs including providing presumptive eligibility determinations for children
3. Ensuring and advocating that the program continues to be available for clients

For more information on ***hawk-i*** outreach, see policy 613 of this manual.

**Early ACCESS
service
coordination**

Early ACCESS (IDEA Part C), Iowa's system of early intervention services, is an interagency partnership at the state and regional levels between the Iowa Department of Education, Iowa Department of Public Health, Iowa Department of Human Services and Child Health Specialty Clinics. The IDEA Part C Infants and Toddlers Program is a

federal initiative that is administered in Iowa by the Iowa Department of Education, which serves as the state's lead agency.

Early ACCESS is a collaboration between Iowa families with young children, and providers from local agencies and other community programs. To be eligible for Early ACCESS services, an infant or toddler must be from birth to age three years and experience a 25 percent or more delay in one or more areas of development or have a high probability of later delay due to a known condition.

In addition to being a referral resource and an active community partner for Early ACCESS, child health contract agencies provide service coordination for the targeted population, children with elevated venous blood lead levels of 20 µg/dL or above. A designated service coordinator helps families to access needed services and resources that will help them with their child's growth and development. An Individual Family Service Plan (IFSP) is developed and periodically reviewed. Early ACCESS services are provided at no cost to the family. Additional information about Early ACCESS is located in policy 609 of this manual.

**Healthy Child
Care Iowa**

The goal of Healthy Child Care Iowa (HCCI) is to improve the overall health status of children enrolled in child care. CH contract agencies are expected to:

- Incorporate public health principles and practices into child care policy and practice
- Provide leadership for developing and implementing the role of public health registered nurses with specialized training to improve the health and safety components of child care

Child health contract agencies are required to provide leadership for development of health and safety in child care. Key activities include securing funding and providing structure for the Child Care Nurse Consultant (CCNC) services to early care and education providers in the community.

A child care nurse consultant is defined in the Iowa Administrative Code 441 IAC 118 as "a registered nurse licensed in the state of Iowa who has completed training using a nationally approved curriculum for health and safety in child care and early education. The child care nurse consultant provides on-site consultation, technical assistance and training to child care and early education providers regarding health and safety. The child care nurse consultant is employed by or has a written agreement with the local MCH contract agency or contracts for service delivery directly through the state-level Title V

maternal and child health program administered by the Iowa Department of Public Health, Bureau of Family Health.”

Infrastructure building activities also include developing local CH contract agency capacity for CCNC services (including assessment of who is providing CCNC services throughout the proposed service area) and establishing written agreements with Child Care Resource and Referral (CCR&R).

CCR&R is the child care business industry’s information and referral source. CH contract agencies are expected to develop professional relationships with child care businesses in all counties within their service delivery area.

CH contract agencies are required to develop professional relationships and establish written agreements with the CCR&R agency(s) for all counties in the service delivery area. The map of current CCR&R regions is located on the website at www.iowaccrr.org/

Training and technical assistance for CCNC is available from the Healthy Child Care Iowa coordinator at the IDPH Bureau of Family Health.

**I-Smile™
program**

A key objective of the I-Smile™ program is to strengthen the oral health infrastructure of local public health to improve the dental support system for families. Each child health contract agency is responsible for developing an integrated, coordinated local service delivery system that includes multiple providers to maximize efficiency of the available workforce.

Each CH contract agency must designate an Iowa-licensed dental hygienist as the I-Smile™ oral health coordinator. The coordinator, with the MCH project director and other applicable staff, is responsible for developing, implementing and integrating the I-Smile™ plan for the service area.

Population-based education is an important component of I-Smile™ to ensure that families receive age-appropriate oral health information and anticipatory guidance. The I-Smile™ dental home concept also relies on strong care coordination services and outreach to families to assist in identifying dental resources in the community, finding payment sources and promoting an understanding of the importance of good oral health.

The I-Smile™ dental home concept recognizes that Iowa's current dental workforce is inadequate to meet the needs of low-income and Medicaid-enrolled children. This requires that child health contract agencies assess local needs and assets to identify clinical resources and increase opportunities for gap-filling oral health screenings and prevention services for underserved children. This may include on-site clinical services or partnerships with other public health service agencies, including WIC, Head Start/Early Head Start and schools.

See section 700 of this manual for additional information on the I-Smile™ program.

**1st Five
Healthy Mental
Development**

IDPH is engaged in advancing strategies designed to improve services that support healthy mental development with a focus on children birth through age five. To promote program development, child health contract agencies are encouraged to participate in selected activities such as specialized training and surveys related to perinatal depression and child development surveillance and testing.

Child health contract agencies are encouraged to advance the following:

- Support the expanded use of recommended surveillance and screening standards within pediatric and family practice medical practices
- Facilitate referrals for children and families needing services and support for healthy mental development
- Promote children's healthy mental development by screening mothers for perinatal depression and making appropriate referrals and interventions
- Integrate components of assessing for children's social/emotional development, autism and possible parental/caregiver stress and depression into Child Health programs
- Collect data related to the healthy mental development of children and families based on guidance from IDPH

Tools:

- The Iowa Child Health Development Record (CHDR) is a recommended tool that includes components for surveillance on family history, social history, family risk factors and anticipatory guidance.
- The Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire for Social and Emotional Development (ASQ:SE) are recommended developmental testing tools.
- The Modified Checklist for Autism in Toddlers (M-CHAT) is a recommended tool for autism screening.

For more information on children’s healthy mental development, see www.iowaEPSDT.org.

Awareness of intimate partner violence and reproductive coercion

Child health contract agencies are encouraged to adopt the *Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion* as best practice for education, referral and training. These guidelines were produced by Futures Without Violence and were funded through the Administration for Children and Families and the Office on Women’s Health, U.S. Department of Health and Human Services. The document is available on the federal website at www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf

Child health contract agencies may refer to policy 601 and appendix A19 for additional information and resources.

Awareness of human trafficking

Child health contract agencies are encouraged to utilize the resources available at the Polaris Project for a World without Slavery regarding the identification of human trafficking victims. The resources are available on the Polaris Project website at www.polarisproject.org/index.php.

Child health contract agencies may refer to policy 601 and appendix A19 for additional information and resources.

Documentation of services

All services provided under the child health program must be entered into the Child and Adolescent Reporting System (CAREs). This web-based record system allows for collection of the child’s demographic information, identification of needs and documentation of services. The CAREs User Manual is found on the IDPH website at www.idph.state.ia.us/hpcdp/common/pdf/CARES_Manual.pdf.

Documentation requirements for informing and care coordination services include:

- Name of client
 - Date of service
 - Place of service (if not agency main address)
 - Time in and time out including a.m. and p.m. – for care coordination and any other service billed based upon timed units
 - Name of person to whom services were provided
 - Scope of the service – issues addressed, information from the
-

- family, outcomes, referrals, refusal of services, etc
- First and last name of provider and credentials (if applicable)
- Signature / signature log

Documentation for interpretation services must include:

- Name of client
- Date of service
- Name of interpreter and/or interpreter's company
- Time in and time out including a.m. and p.m.
- Invoice of cost

Documentation for transportation services must include:

- Name of client
- Date of service
- Who provided the service
- Address where client was picked up
- Destination (medical/dental provider's name and address)
- Invoice of cost
- Mileage if transportation is paid per mile

Documentation of developmental testing must include:

- Name of client
- Date of service
- Name and version of the standardized tool
- Results and interpretation
- Referrals made / action taken
- First and last name of provider and credentials
- Signature of the medical professional

For direct care services provided, a client-based chart must also be maintained for the complete clinical record. Documentation must comply with generally accepted principles for maintaining health records and with requirements established by DHS in Iowa Administrative Code 441 Chapter 79.3 found at www.legis.state.ia.us/ACO/IAChtml/441.htm.

All child health client records (hard copy and/or electronic) are the property of IDPH.

See the Child Health Services Summary on the MCH Project Management Tools website at www.idph.state.ia.us/hpcdp/mch_costing.asp that provides a summary of child health services, documentation requirements, cautions and billing codes.



603 Establishing a Child Health Screening Center

Authority: Iowa Administrative Code 641 IAC 76 and 441 IAC 78.18; CFR 42-441.50-441.62

Effective Date: January 19, 2012

Initial Revision

Replaces: 603—October 2009

Participation

Child health contract agencies are required to meet and maintain qualifications necessary for designation as Medicaid Screening Centers. Programs participating as Medicaid Screening Centers must comply with quality standards and provide continuity of care consistent with guidelines established by the Iowa Department of Public Health. In addition, CH contract agencies must follow the policies for screening centers as outlined in the Medicaid Screening Center Provider Manual found at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf.

Criteria for providing direct care clinical services

Child Health Screening Centers must meet the following criteria in providing direct care clinical services under the child health/EPSDT program:

- Develop protocols for child health/EPSDT services including referral criteria. These must be reviewed and updated on an annual basis or more often if there are Medicaid Screening Center policy changes
- Provide required components of the child health/EPSDT screen according to guidelines in the Medicaid Screening Center Provider Manual
- Provide clinical services that assess the physical and psychosocial needs, health related behaviors and home environment of the client and family
- Select a site for service delivery as described in policy 604 of this manual
- Provide on-going staff development activities
- Employ appropriate licensed personnel for service delivery
- Develop plan for quality assurance
- Provide equipment suitable for performing the services which may include:
 - ◆ Examination table
 - ◆ Portable dental equipment (e.g., patient chair, light)

- ◆ Good light source
- ◆ Developmental screening tool(s)
- ◆ Oral screening supplies (e.g., mouth mirror, gloves, penlight)
- ◆ Emergency tray or cart
- ◆ Height measuring boards or devices that are age appropriate
 - For infants and children to age two, provide a horizontal board with fixed headboard and sliding footboard securely attached at right angles to measuring surface.
 - For children over two, provide a standing height board or stadiometer.
- ◆ Infant and adult balance beam scale with non-detachable weights
- ◆ Standard objective vision testing tool
- ◆ Pure tone audiometer and tympanometer
- ◆ Standard medical supplies
 - Otoscope
 - Stethoscope
 - Sphygmomanometer with appropriate cuff sizes
 - Ophthalmoscope
 - Percussion hammer
 - Thermometer
 - Penlight
 - Consumable supplies such as tongue blades, 2 x 2 gauze, fluoride varnish, alcohol, lancets, syringes, needles, cotton balls, adhesive bandages and urine specimen collection cups
- ◆ Refrigerator used only for vaccine or approved insulated storage chest for vaccine. For specifications contact the IDPH immunization program at 1-800-831-6293.
- ◆ Laboratory testing equipment
 - Hemoglobinometer
 - Urine dipstick that indicates pH, glucose, protein, blood, nitrates
 - Lead screening equipment

Note that the University Hygienic Lab (UHL) can set up an account and furnish tubes and mailers. The UHL bills Medicaid for the lead lab analysis for children up to 72 months of age. A Clinical Laboratory Improvement Amendment (CLIA) waiver is required if hemoglobin, dipstick urinalysis or blood lead analysis is done at the CH contract agency. (See policy 605 of this manual.)

CH contract agencies may obtain waiver information by contacting the CLIA Laboratory Consultants at the University of Iowa Hygienic Laboratory at 1-800-421-4692 or through the website at www.uhl.uiowa.edu/services/clia/certificates.xml. Also see the 'CLIA

Corner' at www.uhl.uiowa.edu/publications/cliacorner/.

- Develop forms for documentation of:
 - ◆ Patient information
 - ◆ Income
 - ◆ Release of confidential information that includes IDPH ownership and access to records
 - ◆ Age appropriate health history and medical and dental screening summary
 - ◆ Immunization records
 - ◆ Growth chart (See appendix A12 of this manual.)
 - ◆ Lead exposure questionnaire
- Comply with documentation requirements by recording:
 - ◆ Subjective data including opinions, perceptions, feelings and ideas about health status
 - ◆ Objective data, which is both observable and measurable including physical assessment, relevant laboratory reports and diagnostic findings
 - ◆ The plan developed after considering the client's need for referral as a result of the screening process. See documentation requirements in Iowa Administrative Code 441 IAC 79.3 (2).
- Document services using the IDPH Child and Adolescent Reporting System (CAREs). Maintain a client-based chart for the complete clinical detail and forms for direct care services. Assure that documentation complies with generally accepted principles for maintaining health records and with requirements established by DHS in IAC 441 Chapter 79.3 found at www.legis.state.ia.us/ACO/IAChtml/441.htm.
- Maintain a system of referral and follow-up
 - ◆ Develop a system to assure that client follow-up is completed and documented
 - ◆ Provide follow-up of canceled or missed appointments and re-schedule initial and return appointments
- Provide informing and care coordination services
 - ◆ Develop protocols that describe how informing and care coordination services will be provided (Refer to the EPSDT *Care for Kids* Informing and Care Coordination Handbook.)
 - ◆ Develop strategies that will be used to inform primary care providers and consumers of the availability of care coordination services
 - ◆ Maintain adequate hardware and software to accommodate the CAREs data system
- Provide recommended office and/or reception area equipment including:
 - ◆ Office furniture

- ◆ Tables, chairs, wastebaskets, for reception area and exam rooms
- ◆ Racks for display of literature for clients
- ◆ File cabinets with locks
- ◆ Telephones
- ◆ FAX machine
- ◆ Copy machine
- ◆ Computer
- ◆ Modem
- ◆ Printer
- ◆ Standard office supplies
- ◆ Age-appropriate toys



604 Site Selection for MCH Service Delivery

Authority: Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act 1990, PL 103-227
Effective Date: January 19, 2012
Initial Revision
Replaces: 604—October 2008

Determination Careful consideration should be given to the site selection for the location of MCH services. Whenever possible, services should be provided in a location that is easily accessible to target populations and in close proximity to, or within, other community agencies serving children and their families. Each community has its own unique needs and resources. Decisions need to be made that assure quality of service delivery and client safety. Before beginning a search for a location, needs should be identified and prioritized.

In choosing sites, identify space that:

- Is accessible for clients and staff with disabilities and in compliance with the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the 1973 Rehabilitation Act or any successor documents;
- Provides a layout and square footage that accommodates and facilitates service to families;
- Provides a comfortable waiting room, an adequate reception area and a play area;
- Is clean and free of clutter;
- Features a comfortable temperature;
- Offers private areas for client interview;
- Includes a sufficient number of enclosed single examination rooms to accommodate service needs, the projected number of clients per hour and allows for private conversations;
- Provides office space separate from client service areas for staff to make follow-up phone calls and complete documentation;
- Meets local fire, building and licensing codes;
- Complies with Title VII of the Civil Rights Act of 1964 prohibiting discrimination based on race, color or national origin in programs or activities which receive federal financial assistance; and
- Includes a storage room area for files and supplies.

ADA and 504 Compliance with the ADA and 504 requirements include:

compliance requirements

- Evaluation of the site for accessibility including written documentation of the evaluation and the name of the person doing the evaluation;
 - Appointment of an agency coordinator for assurance of ADA and 504 requirements;
 - Preparation and willingness to provide “reasonable accommodation” to a disabled applicant or employee who requests it;
 - Orientation of the agency supervisor to ADA and 504 requirements.
 - The MCH contract agency’s compliance with the ADA and 504 requirements are evaluated during the agency administrative on-site review. (See form in appendix A10.)
-

Federal requirements for environmental tobacco smoke

Public Law 103-227, also known as the Pro-Children Act of 1994, requires that smoking not be permitted in any portion of any indoor facility owned, leased or contracted by an organization and used routinely for the provision of health, child care or early childhood development service, education or library services to children under age eighteen, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are contracted, operated or maintained with such federal funds.

The MCH contract agency must comply with the requirements of the act and not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the act. In addition, subcontractors are also obligated to comply with the tobacco smoke regulations.

Signage

The MCH contract agency should display safety information signage such as weapon, smoking and animal restrictions (except service animals), prominently at the entrance to the facility



605 CLIA Regulations

Authority: Contract General Conditions 32; Clinical Laboratory Improvement Amendments (CLIA) of 1988
Effective Date: January 19, 2012
Initial Revision
Replaces: 605—October 2009

Requirements Any MCH contract agency conducting laboratory testing in the provision of services through a contract with IDPH must be certified and in substantial compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as required by the Centers for Medicare and Medicaid Services (CMS).

CLIA requires every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention or treatment of any disease or the assessment of the health of a human being, to meet certain federal requirements. In addition, the CLIA legislation requires financing of all regulatory costs through fees assessed to laboratories. CLIA applies to any facility performing laboratory testing as outlined above, even if only one or a few basic tests are performed, and even if the facility is not charging for testing.

Waivers CLIA waivers are available for a variety of tests frequently provided in the clinic setting. For a list of the tests granted waivers under CLIA, visit the CMS website at www.cms.hhs.gov/CLIA/downloads/waivetbl.pdf.

In addition, a certificate is available for physician-performed microscopy procedures. If a physician (an M.D., D.O. or D.P.M.) personally performs these tests on patients of his or her own medical practice (including a group practice of which the physician is a member), the laboratory may receive a certificate for physician-performed microscopy procedures. Under this certificate, the laboratory is also permitted to conduct waived tests; however, no other tests may be performed. See the CMS CLIA brochure at www.cms.hhs.gov/MLNProducts/downloads/CLIABrochure.pdf. More information can be found on the CMS website at

www.cms.hhs.gov/clia/.

To apply

To apply for the CLIA program, form CMS 116 must be completed and returned to CMS within 30 days of receipt. This form collects information about a laboratory's operation and is necessary to assess fees, to establish baseline data and to fulfill the statutory requirements of the Public Health Service Act. This information will provide the laboratory supervisor with an overview of the laboratory's operation if it is subject to an on-site survey.

For additional information and application for the CLIA program or a waiver, contact www.cms.hhs.gov/clia/ or the

University of Iowa Hygienic Laboratory
CLIA Lab Program
102 Oakdale Campus
OH H101
Iowa City, IA 52242
(319)335-4500

www.uhl.uiowa.edu/services/clia/index.xml



606 Client Records

Authority: IDPH General Conditions
Effective Date: January 19, 2012
Initial Revision
Replaces: 606—October 2008

Maintenance & property rights

Client records will be maintained on the MCH data systems, CARES and WHIS. Additional information related to direct care services provided and contacts with a client may be kept in hard copy or electronic medical record according to the MCH contract agency's protocol. MCH contract agencies will assure that employees are allowed access to client records (electronic or paper only) as necessary for the performance of their duties related to the contract and in accordance with policies and procedures.

MCH client records are the property of the Iowa Department of Public Health. In the event that an MCH contract is terminated IDPH will provide direction for the transfer of client records.

Record retention

The IDPH General Conditions, effective 10-1-2009 outline record retention requirements. The document states, "The CONTRACTOR will retain all medical records for a period of six years from the day the CONTRACTOR submits its final expenditure report; or in the case of a minor patient or client, for a period of one year after the patient or client attains the age of majority, whichever is later." The IDPH general conditions are located on the IDPH website at www.idph.state.ia.us (under "funding opportunities").

See policy 305 and appendix A7 of this manual for more information on HIPAA and the business associate agreement between the Iowa Department of Public Health and the Iowa Department of Human Services.

Security

It is recommended that MCH contract agencies use encryption software to protect against unauthorized users.

MCH contract agencies must notify IDPH prior to upgrading or transferring computers.

IDPH electronic/computer applications may only be accessed within the offices and clinics of the MCH contract agency. MCH contract agencies using wireless connections must ensure that the wireless connections are secure, requiring a password to connect to the wireless network. MCH contract agencies may not access IDPH applications on an open access wireless network (e.g., Wi-Fi connection at local coffee shops or staff members' homes).



607 Reportable Infectious Diseases

Authority: Iowa Administrative Code 641 IAC 1

Effective Date: January 19, 2012

Initial Revision

Replaces: 607—October 2008

Reporting infectious diseases

See the Reportable, Communicable and Infectious Disease Poster in the IDPH Epi Manual section on Reportable Disease Information for the most current information at www.idph.state.ia.us/idph_universalhelp/main.aspx?system=idphEpiManual.

The following infectious diseases are required to be reported to the state and local public health offices:

Acquired Immune Deficiency Syndrome (AIDS)

Anthrax

Arboviral Diseases

Botulism

Brucellosis

Campylobacteriosis

Chlamydia trachomatis

Cholera

Cryptosporidiosis

Cyclosporea

Diphtheria

Enterococcus invasive disease

E. Coli

Giardiasis

Gonorrhea

Group A Streptococcus invasive disease

Haemophilus influenza type B invasive disease

Hansen's Disease (Leprosy)

Hantavirus syndromes

Hepatitis, viral (A, B, C, D, E)

Human Immunodeficiency Virus (HIV) infection other than AIDS
Legionellosis
Listeria monocytogenes invasive disease
Lyme disease
Malaria
Measles (Rubeola)
Meningococcal invasive disease
Mumps
Pertussis
Plague
Poliomyelitis
Psittacosis
Rabies (human and animal)
Rocky Mountain Spotted Fever
Rubella (measles, including congenital)
Salmonellosis (including Typhoid Fever)
Severe Acute Respiratory Syndrome (SARS)
Shigellosis
Smallpox
Staphylococcus aureus
Syphilis
Tetanus
Toxic Shock Syndrome
Trichinosis
Tuberculosis
Viral hemorrhagic fever
Yellow Fever
Any other disease which is unusual in incidence, occurs in unusual numbers or circumstances or appears to be of public health concern; for example, epidemic diarrhea, foodborne or waterborne outbreaks and acute respiratory illness

Forms To report infectious diseases, use the Disease Reporting Card from the Iowa Department of Public Health, Center for Acute Disease Epidemiology. These forms can be obtained by calling the state clearinghouse at 1-888-398-9696. Fax the appropriate copies to both the state **(515) 281-5698** and the local public health offices. Faxing to IDPH is preferred, but mailing is acceptable.

Report by **Report the following diseases immediately by telephone** to the local health department and the Center for Acute Disease

phone Epidemiology at the Iowa Department of Public Health at **1-800-362-2736**.

Botulism
Cholera
Diphtheria
<i>Haemophilus Influenzae</i> , type B Invasive Disease
Meningococcal invasive disease
Plague
Poliomyelitis
Rabies (Human)
Rubeola (Measles)
Severe Acute Respiratory Syndrome (SARS)
Smallpox
Tuberculosis- pulmonary and laryngeal
Vancomycin-resistant <i>Staphylococcus aureus</i>
Viral Hemorrhagic fever
Yellow Fever
Disease outbreaks of any health concern

Report directly to UHL Reportable only by sending isolates to the University Hygienic Laboratory:

- Enterococcus invasive disease
- Group A Streptococcus invasive disease
- Methicillin-resistant *Staphylococcus aureus* invasive disease
- Streptococcus pneumoniae invasive disease

Infectious Disease Surveillance System The Iowa Disease Surveillance System (IDSS) enables local public health, hospitals, laboratories and IDPH to collaborate electronically as they perform disease reporting and surveillance activities across the state. IDSS was first implemented in the Center for Acute Disease Epidemiology (CADE) in October 2008 and is now widely used by hospitals, laboratories and public health agencies statewide. For more information go to www.idph.state.ia.us/adper/idss.asp.



608 EPSDT *Care for Kids* Program

Authority: Iowa Administrative Code 441 IAC 84; 42CFR 441.B

Effective Date: January 19, 2012

Initial Revision

Replaces: 608—October 2009

Overview

Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is authorized by Title XIX of the Social Security Act and provides preventive health coverage for services to children from birth to age 21 years. It is designed to increase the number of Medicaid enrolled children who achieve and maintain optimal health and development. The EPSDT *Care for Kids* program emphasizes a periodic schedule of services including comprehensive preventive health screening, diagnosis and treatment of disease or developmental delay.

Medicaid's EPSDT program provides the model of services for all children served through child health programs, regardless of payer source.

Upon approval of the Title V application to IDPH, child health contract agencies must apply for and receive approval as a Medicaid Screening Center. In Iowa, the Iowa Medicaid Enterprise (IME) contracts with IDPH for developing and maintaining local capacity for informing, care coordination and medical and oral health screening services. Under this contract, child health contract agencies are required to maintain quality standards for services as outlined in the Medicaid Screening Center Provider Manual found at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf.

See the IDPH EPSDT website at www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp for numerous program resources. The map of Title V service areas and designated EPSDT coordinators is found at www.idph.state.ia.us/webmap/default.asp?map=epsdt.

Eligibility for the EPSDT

All Medicaid enrolled children are automatically enrolled in the EPSDT *Care for Kids* program. Under Medicaid, children may be classified as

program

fee-for-service, MediPASS or Medicaid HMO members.

- Fee for service: Any practitioner approved by Medicaid may provide health care services. All Medicaid oral health services are fee-for-service.
- MediPASS: Medicaid's Patient Access to Service System. Physicians that enroll as MediPASS providers serve as a 'gatekeeper' to assess a client's need for health care services and provide approvals for referral for specialized care.
- Medicaid HMO: Clients enrolled in a Medicaid health maintenance organization (HMO) must access services from a medical provider within the Medicaid HMO panel. Direct care services provided by a physician or nurse practitioner outside of the HMO panel of providers are not covered by Medicaid.
 - Medicaid HMO clients may receive presumptive eligibility, informing and care coordination services from an MCH contract agency, and the MCH contract agency may bill IDPH for these services.
 - Dental services remain fee-for-service. Dental services are not impacted by a client's Medicaid HMO status.

Child health program responsibilities

Child health contract agencies are responsible for developing and maintaining local capacity for informing, care coordination, comprehensive preventive medical screenings and gap-filling oral health services.

Comprehensive preventive screenings (well child examination) and oral health services must meet one of the following:

- Be assured for all children served in the service area
- Provided directly by the child health contract agency with direct care responsibilities defined in the agency's approved MCH application.

Whether providing the full well child screen or selected gap-filling direct care services, child health programs are responsible for assuring that the children they serve receive regular well child health care. As a child health program, providing selected gap-filling services does not preclude the CH contract agency's responsibility for assuring the well child health care for a child.

Each child health program is responsible for developing, implementing and maintaining written protocols for informing and care coordination services consistent with the guidelines in the EPSDT *Care for Kids* Informing and Care Coordination Handbook found at

www.idph.state.ia.us/hpcdp/common/pdf/epsdt_handbook.pdf.

Protocols for direct care services must be consistent with the Medicaid Screening Center Provider Manual found at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf.

EPSDT coordinator

Child health programs must have a designated EPSDT coordinator. The child health (CH) program coordinator may either serve in a dual role as the EPSDT coordinator or may delegate the duties to qualified staff. If different individuals are assigned to the two positions, the EPSDT coordinator will report to the CH program coordinator.

The EPSDT *Care for Kids* Program coordinator is required to possess at least one of the following:

- Current license as a registered nurse (RN)
 - Current license as a registered dental hygienist (RDH)
 - Bachelor's degree in health education, social work, counseling, sociology or psychology
-

Informing and care coordination

Informing and care coordination services are provided to assist families in accessing EPSDT *Care for Kids* screening services.

Through the informing process, families of newly Medicaid eligible children are advised of the services available through the EPSDT *Care for Kids* program. Child health programs are responsible for informing families of all newly enrolled Medicaid children within 30 calendar days of the beginning of each month. Families that cannot be reached after multiple attempts or families who refuse services should be re-informed of the EPSDT *Care for Kids* services in six months (for children under age 2) or in a year (for children age 2 and over).

Informing services include:

- Explaining the benefits of preventive medical and dental care
 - Encouraging families to find medical and dental homes
 - Explaining the screening services available under the EPSDT *Care for Kids* program
 - Explaining care coordination services that can provide assistance with arranging medical, dental and mental health appointments; transportation services to medical, dental and mental health appointments; and medical, dental, mental health interpretation services
 - Explaining what to expect when a child receives a medical or dental screen
 - Providing information as to where community resources are located and how to obtain them
 - Assuring that families have freedom of choice in selection of primary care providers
-

Care coordinators assist families by linking their children to quality community-based preventive health services for screening, diagnosis and/or treatment. Care coordinators help families find appropriate community resources, overcome barriers as they navigate the health care system, monitor each child's progress through the system and enable families to become more effective health care consumers. CH contract agencies provide care coordination services to Medicaid-enrolled families covered under fee-for-service, MediPASS and Medicaid HMOs. CH contract agencies also provide care coordination for children who are uninsured or under-insured.

Care coordination is provided via phone or face-to-face contacts with the family, including home visits. Billable care coordination services must include linkage to medical, dental and mental health and/or other Medicaid related services/programs. Care coordination activities include:

- Contacting families to remind them of periodic medical and dental exams
- Assisting families to schedule appointments as needed (external to the agency)
- Reminding families of appointments
- Following-up with families on missed appointments
- Working with the child's medical and dental private practitioners to coordinate care
- Assisting families when referral for further medical, dental and/or mental health services are indicated
- Arranging transportation to medical/dental/mental health appointments
- Arranging medical/dental/mental health interpretation services
- Conducting follow-up to determine if services have been received

Note: Care coordination provided in conjunction with a direct care service is considered part of the direct care and cannot be billed separately. Additionally, care coordination provided at the time of an informing service is considered part of the informing process.

The EPSDT *Care for Kids* Informing and Care Coordination Handbook, found at www.idph.state.ia.us/hpcdp/common/pdf/epsdt_handbook.pdf, provides program guidelines for implementing informing and care coordination services.

Staff members providing informing and care coordination services are required to possess at least one of the following:

- Current license as a registered nurse (RN)

- Current license as a registered dental hygienist (RDH)
- Bachelor's degree in social work, counseling, sociology, family and consumer sciences, health and human development, health education, individual and family studies or psychology
- Current license as a licensed practical nurse (LPN) or paraprofessional working under the direct supervision of one of the health professionals listed above

Staff members providing informing and care coordination services must provide services within their professional scope of practice. Child health programs must have a job description or protocol on file that defines the role of the LPN or paraprofessional and supervision activities by the health professional. Clerical staff may assist with mailings as needed.

**EPSDT
screening
services**

Guidelines for EPSDT screening services are found in the Screening Center Provider Manual at www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf.

Screenings are to be provided according to the Iowa EPSDT *Care for Kids* Health Maintenance Recommendations found on the IDPH EPSDT Providers website at www.idph.state.ia.us/hpcdp/epsdt_providers.asp. This schedule is based upon guidelines established in Bright Futures, 3rd Edition, American Academy of Pediatrics.

The EPSDT well child screen includes:

- Comprehensive health and developmental history, including assessment of both physical and mental health development. This includes a developmental assessment and assessment of nutritional status.
- Comprehensive unclothed physical examination including assessment of physical growth, physical inspection of ears, nose, mouth, throat and all organ systems such as pulmonary, cardiac and gastrointestinal systems (Appendix A12 of this manual contains links to CDC age-based growth charts.)
- Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health (See the CDC's Advisory Committee on Immunization Practices (ACIP) Childhood Immunization Schedules at www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable.)
- Health education including anticipatory guidance
- Hearing and vision screening
- Appropriate laboratory tests including hematocrit or

hemoglobin, rapid urine screening, tuberculin test (when appropriate), hemoglobinopathy (when appropriate) and serology (when appropriate)

- Blood lead testing for all children age 12-72 months according to guidelines established in the Medicaid Screening Center Provider Manual
- Medically necessary nutrition counseling services (when appropriate)
- Oral health screening that includes medical and dental history, hard and soft tissue evaluation and age-appropriate oral health education
- Referral to a dentist by age 12 months and periodically thereafter as indicated by risk assessment

EPSDT well-child screenings may be done by qualified personnel through a child health contract agency, a private physician or by other service providers. Other service providers as defined in the Iowa Code for scope of practice include family and pediatric nurse practitioners, rural health centers and federally qualified health centers.

EPSDT oral health screenings may be done by a dentist, registered dental hygienist, physician, physician assistant, advanced registered nurse practitioner or registered nurse.

All Iowa physicians that accept Medicaid reimbursement are considered EPSDT *Care for Kids* providers. The family of a Medicaid eligible child may utilize any provider of choice. However, clients enrolled in MediPASS are limited to a designated panel of providers. Clients enrolled in a Medicaid HMO are limited to the HMO's panel of providers for their medical care.

Diagnosis

If the screening indicates a need for further evaluation, a referral for diagnosis is made and the child receives a complete diagnostic evaluation. Diagnosis may also be part of the screening process.

Treatment

Need for treatment identified through an EPSDT screen is provided by a Medicaid provider that may be a physician, dentist, Early ACCESS provider or facility qualified to evaluate, diagnose and treat a child's health problem(s). Reimbursement by Medicaid for treatment of conditions found during an EPSDT screening may be available even if Medicaid does not generally cover the services.

Transportation Medicaid provides direct payment to child health programs for *local*

services *(in-town)* transportation services to take children to Medicaid providers for medical, dental or mental health appointments. Child health programs submit a transportation plan to IDPH each year that identifies the modes of transportation to be used (bus, taxi, wheelchair accessible vehicle, volunteer and/or non-profit transportation system) and their costs.

The Iowa Department of Human Services also contracts with Transportation Management Services (TMS) to handle arranging and paying for in-town and out-of-town transportation services for Medicaid members. For child health programs, TMS can be especially helpful in arranging for out-of-town transportation services for medical, dental or mental health appointments. Contact TMS at 1-866-572-7662 at least 72 hours in advance of the appointment to make arrangements.

Interpretation services Under the EPSDT program, Medicaid provides direct payment for interpretation services provided in conjunction with another Medicaid covered service (informing, care coordination, medical, dental or mental health services). Interpretation services include sign language or oral interpretive services and telephonic oral interpretive services.

Billable interpretation services are provided by individuals who provide **only** interpretive services. These interpreters must be employed or contracted by the child health contract agency, but may not have shared job roles within the agency other than providing interpretation services. Medical staff that are bilingual are reimbursed for their medical services but not for any interpretation that they may provide.

It is the responsibility of the child health contract agency to determine the interpreter's competency. Sign language interpreters must be licensed pursuant to Iowa Administrative Code 645 Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org).

Cost analysis Each year child health programs are required to determine the cost for services provided. Services provided under the EPSDT program are included in this cost analysis. The child health program is required to bill Medicaid their actual cost for services. The cost analysis is completed using IDPH approved methodology and forms. The MCH Cost Analysis and Transportation Plan are submitted to IDPH and maintained on file by the CH contract agency. Policy 402 of this manual contains additional cost analysis information.

Compliance with Medicaid regulations

Child Health Screening Centers must comply with regulations established by the Centers for Medicaid and Medicare Services and the Iowa Medicaid Enterprise (IME). Upon enrollment, Medicaid providers enter into an agreement with the IME that specifies contractual responsibilities. Iowa Administrative Code for Iowa DHS is found at www.legis.state.ia.us/ACO/IAChtml/441.htm. Chapters 78, 79 and 84 are of particular importance to Child Health Screening Centers.

Documentation

All services provided under the child health program must be entered into the Child and Adolescent Reporting System (CAREs), including those provided under the EPSDT program. This web-based record system allows for collection of the child's demographic information, identification of needs and documentation of services. The CAREs User Manual is found on the IDPH website at www.idph.state.ia.us/hpcdp/common/pdf/CARES_Manual.pdf.)

Documentation requirements for informing and care coordination services include:

- Name of client
- Date of service
- Place of service (if not agency main address)
- Time in and time out including a.m. and p.m. – for care coordination and any other service billed based upon timed units
- The person with whom the contact was made
- Scope of the service – issues addressed, information from the family, outcomes, referrals, etc.
- First and last name of provider and credentials (if applicable)
- Signature / signature log

Documentation for interpretation services must include:

- Name of client
- Date of service
- Name of interpreter and/or interpreter's company
- Time in and time out including a.m. and p.m.
- Invoice of cost

Documentation for transportation services must include:

- Name of client
- Date of service
- Who provided the service
- Address where client was picked up
- Destination (medical/dental provider's name and address)

- Invoice of cost
- Mileage if transportation is paid per mile

Documentation of developmental testing must include:

- Name of client
- Date of service
- Name and version of the standardized tool
- Results and interpretation
- Action taken
- First and last name of provider and credentials
- Signature of the medical professional

For direct care services provided, a client-based chart must also be maintained for the complete clinical record. Documentation must comply with generally accepted principles for maintaining health records and with requirements established by DHS in Iowa Administrative Code 441 Chapter 79.3 found at www.legis.state.ia.us/ACO/IAChtml/441.htm.

All child health client records (hard copy and/or electronic) are property of IDPH.

See the Child Health Services Summary on the MCH Project Management Tools website at http://www.idph.state.ia.us/hpcdp/mch_costing.asp. MCH contract agencies can obtain the password for the website by calling the Bureau of Family Health toll-free number, 1-800-383-3826. The document provides a summary of child health services, documentation requirements, cautions and billing codes.

Centers for Medicare and Medicaid Services (CMS) 416 Report

Annually, Iowa DHS sends data to the Centers for Medicare and Medicaid Services (CMS) providing basic information on participation in Medicaid's EPSDT program. Information in this CMS 416 Report is used to assess the effectiveness of state EPSDT programs in providing access to medical screening services, dental services and referral for corrective treatment. CMS uses the information to measure whether states are meeting the goals set by Congress and to develop trends and projections for the nation and individual states. Information is also used to respond to congressional and public inquiries.

In Iowa, the report is used to assess needs in individual counties and assure that children across the state are accessing services. Child health contract agencies are responsible for maintaining a minimum participation rate of *80 percent* for EPSDT *Care for Kids* screening services in each county of their service area as measured by the CMS

416 report.

Each year IDPH uses the data from the CMS 416 report to compile a state report of participation in EPSDT by county. The CMS 416 report includes services from October 1 through September 30 for all Medicaid eligible children from birth to age 21 years in Iowa. A broad range of preventive codes is used to capture all initial and periodic screening services.

Participation rates on the CMS 416 report represent the percent of Medicaid eligible children who receive at least one initial or periodic screening service during the year. This is determined by a formula that checks for the number of expected visits based upon the period of eligibility and the expected number of screenings during that time period.

As a result:

- The participation rate for children ages two and under only indicates the percent of Medicaid children who received at least one screen per year. It does not demonstrate that these children are up-to-date with *all* recommended screenings per the Iowa EPSDT *Care for Kids* Health Maintenance Recommendations.
- If children over the age of six years receive screens annually, they are counted once for any given year. Because the Iowa EPSDT *Care for Kids* Health Maintenance Recommendations identify that screens are needed every *other* year for children age six and above, participation rates may reach or exceed 100 percent for older children. If rates reach or exceed 100 percent, it should not be interpreted that all enrolled children have received at least one screen per year.

The CMS 416 Participation Rates are posted on the IDPH EPSDT website at www.idph.state.ia.us/hpcdp/epsdt_providers.asp.

The CMS 416 Report for dental services measures the percent of all Medicaid children receiving any dental or oral health service, any oral health service by a non-dentist and any dental service in the fiscal year. The annual Dental Services Reports are posted on the IDPH Bureau of Oral and Health Delivery Systems website at www.idph.state.ia.us/hpcdp/oral_health_reports.asp.



609 Early ACCESS

AUTHORITY: PUBLIC LAW 105-17; IDEA '97: PART C; IOWA ADMINISTRATIVE
CODE 281 IAC 120.4-120.8
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 609—OCTOBER 2009

Federal Context

The Individuals with Disabilities Education Act (IDEA)

Congress created Part C of IDEA to assist states to design and implement systems of early intervention services for infants and toddlers with disabilities and their families. Statewide early intervention systems differ from state to state in areas such as setting the criteria and definitions for child eligibility and identifying which state agency has been designated "lead agency" for the Part C program.

Congress established this program in 1986 in recognition of "an urgent and substantial need" to enhance the development of infants and toddlers with disabilities; reduce educational costs by minimizing the need for special education through early intervention, minimizing the likelihood of institutionalization and maximizing independent living; and enhance the capacity of families to meet their child's needs.

The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, from birth through age 2 years and their families.

Iowa Context

Early ACCESS

Iowa's program, called Early ACCESS, is a partnership between families with young children, birth to age three years, and providers from the state departments of education, public health and human services and Child Health Specialty Clinics. The purpose of this program is for families and staff to work together in identifying,

coordinating and providing needed services and resources that will help the family assist their infant or toddler to grow and develop.

The family and providers work together to identify and address specific family concerns and priorities as they relate to the child's overall growth and development. In addition, broader family needs and concerns can be addressed by locating other supportive/resources services in the local community for the family and/or child.

All services to the child are provided in the child's natural environment including the home and other community settings where children of the same age without disabilities participate.

Eligibility and cost

An infant or toddler under the age of three years (birth to age three) who, has a condition or disability that is known to have a high probability of later delays if early intervention services were not provided, or is already experiencing a 25 percent delay in one or more areas of growth or development is eligible for Iowa's Early ACCESS program.

There are no costs to families for the following:

- Service coordination activities
- Evaluation and assessment activities to determine eligibility or identify the concerns, priorities and resources of the family
- Activities related to development and reviews of the Individualized Family Service Plan

Contact information for Iowa's Early ACCESS program includes the following:

Monday through Friday, 8:00 a.m. to 7:00 p.m.

1-888-IAKIDS1 (1-888-425-4371)

Website: www.EarlyACCESSIowa.org

System Commitment

Memorandum of agreement

The commitments of the four signatory agencies (Iowa Department of Education, Iowa Department of Public Health, Iowa Department of Human Services and Child Health Specialty Clinics) provide the vision, leadership and resources needed to have a coordinated, interagency, family-centered system of services, consistent with Individuals with Disabilities Education Act, Part C [20 U.S.C. 631].

The agreement addresses federal interagency agreement requirements and describes the commitments of the signatory

agencies for the Early ACCESS system, consistent with the provisions of the Individuals with Disabilities Education Act / Part C, regarding:

- Financial responsibility
- Dispute resolution of child, family and system issues
- Administration support and leadership
- System requirements and improvements
- Resource commitments

These signatory agencies are committed to sustaining and continually improving the Early ACCESS system in Iowa, which is a comprehensive, coordinated, multi-disciplinary, resource-based, interagency system of services for infants, toddlers and their families. The agreement encourages a balance between flexibility of services and resources, while maintaining quality and uniformity throughout the state.

The signatory agencies agree to commit to administrative support and leadership of the Early ACCESS system. Signatory agencies agree to recommend management level representatives to the governor for appointment to the Iowa Council for Early ACCESS. Signatory agency appointees agree to fully participate on the council, the executive committee of the council and other committees as appropriate for the following purposes:

- To build dynamic relationships that constitute the comprehensive system of services known as Early ACCESS
- To promote standardization and uniformity of Early ACCESS services statewide
- To develop and promote linking with other public and private partners
- To maintain and improve the infrastructure for Early ACCESS
- To ensure equitable distribution of resources based on the mission, vision and capacity of each partner and other available resources within the state
- To promote a comprehensive child find system
- To ensure and promote a central point of contact and directory
- To continually monitor Early ACCESS services and implementation of IDEA throughout Iowa including identification and correction of barriers to an effective system of services
- To meet and communicate regularly for the purpose of carrying out the above responsibilities

Each signatory agency commits to implementing state Early ACCESS policies and Iowa Administrative Rules for Early ACCESS for the following infrastructure system components:

- Central directory
- Public awareness/child find system

- Evaluation and assessment
- Service coordination
- Individualized Family Service Plan
- Early intervention services in natural environments
- Procedural safeguards
- Funding and financial matters
- Sharing of information and data management
- Personnel standards
- Comprehensive system of personnel development
- Continuous improvement and monitoring
- Identification and coordination of available resources
- Interagency agreements
- Resolution of child, family and system issues
- State interagency coordinating council

The signatory agencies agree to revise state policies and administrative rules for the purposes of improving the system and aligning with federal requirements and state laws.

The signatory agencies are committed to move toward:

- Building true collaboration
- Blending services
- Building trust at the service level
- Engaging the services and resources from the signatory agencies more broadly
- Strengthening relationships with the private sector
- Creating an environment for sustainability

Furthermore, the signatory agencies commit to champion the principles of the Early ACCESS system within their own programs and internal environments.

The signatory agencies will engage in activities to build stronger linkages to health providers as a whole, link data, strengthen the governance model and structures to be more system oriented and support a “sustainable communities” concept in the context of the macro level trends of the future. Activities will be directed by a five year work plan of action including:

- A review of administrative rules to reaffirm and revise the current document with emphasis on interpretations in the current environment and watchful of future trends
- Reaffirmation and clarification of staff liaison positions
- Implementation and assessment of new and ongoing initiatives
- Design of an effective, flexible financial system
- Discussion of policy changes as appropriate

**Iowa
Department of
Public Health
commitment**

The Iowa Department of Public Health is a signatory partner in the statewide Early ACCESS system. As a signatory partner of the Early ACCESS system, Iowa Department of Public Health, child health contract agencies will participate in the Early ACCESS system in an effort to better meet the child and family's needs. (Iowa Administrative Code 281 IAC 120.4-120.8)

The Iowa Department of Public Health has identified specific populations of children to receive Early ACCESS services. In the attempt to best match service providers with family needs, target populations have been identified based on the scope of practice of child health service providers. Lead poisoned children (venous blood lead level greater than or equal to 20 µg/dL) is the initial population for which child health contract agencies will provide Early ACCESS developmental evaluation, assessment and service coordination. Additional populations may be added at a later date.

Child health contract agencies will only provide service coordination for newly referred children; they will not take over as service coordinators for children that have an active Individualized Family Service Plan (IFSP) and are being served elsewhere by the Early ACCESS system.

A consistent developmental evaluation tool, Developmental Assessment of Young Children (DAYC), has been selected and will be used to monitor this population across the state. The initial purchase of the DAYC tool will be secured by IDPH.

Child health contract agencies will provide service coordination and monitor the development of children within the target population. The scope of practice of child health service coordinators includes children who are generally appropriately developing. It is not the intent of IDPH to provide service to children with significant developmental delays.

If it is determined that a child with a venous blood lead level that is greater than or equal to 20 µg/dL has significant developmental delays and could be most appropriately served by an Area Education Agency (AEA) service coordinator, then the child will be transferred to an AEA service coordinator.

Service Delivery System

**Iowa
Department of
Public Health**

The Iowa Department of Public Health will:

- Identify staff to serve as the Early ACCESS state contact for child health contract agencies

- Provide supervision to Early ACCESS service coordinators in child health contract agencies
 - Provide technical assistance to child health Early ACCESS service coordinators
 - Complete quality assurance activities including, but not limited to, chart audits
 - Track child health service coordinator training and assure competency
 - Identify staff to participate in the comprehensive system of personnel development
-

Child health contract agency expectations

Child health service coordinators will receive appropriate training and meet Early ACCESS service coordinator competencies that have been set forth by the Iowa Department of Education.

Child health service coordinators will maximize the use of Medicaid as a payment source.

Child health service coordinators will follow service delivery protocols as outlined by the Iowa Department of Public Health and approved by the Iowa Department of Education. The Early ACCESS Service Coordination Checklist is located in appendix A20 of this manual.

When a referral is received, the child health service coordinators will call the local Area Education Agency (AEA) to check to see if the child is already receiving services from Early ACCESS.

If the child is already in the system, then the child health service coordinator will not make contact with the family. The child health service coordinator will contact the lead program case manager and inform them that the child is already receiving Early ACCESS services.

If the child is not in the Early ACCESS system, the child health service coordinator will send via email or fax the completed intake/referral form to the IDPH Early ACCESS liaison to be entered into the web-based IFSP database so that the child can be assigned to the child health service coordinators caseload. The child health service coordinator will then contact the family to initiate services and complete the developmental assessment.

The child health service coordinator will document contacts with the family and complete IFSP forms in the web-based IFSP database. The child health service coordinator will send copies of the signed Early ACCESS consents and releases to the AEA regional liaison/coordinator so that the child can be entered into the Information

Management System (IMS), the statewide AEA computer system.

If, at any time, the family's demographic information changes, the child health service coordinator will update the web-based IFSP database.

Part B of the Individuals with Disabilities Education Act provides for early childhood special education services for children three to five years of age and their families. Part B services are provided by area education agencies (AEAs) and local school districts. When a child is two years and three months of age, the child health service coordinator will consider a Part B referral and, if appropriate, will contact the AEA to begin Part B transition planning.

Once the child has exited Early ACCESS, the child health service coordinator will send all the original signed Early ACCESS consents and releases as well as any other paperwork that is part of the child's file to the AEA regional liaison/coordinator. Some AEAs may also request a hard copy of the child's IFSPs.

The child health service coordinator will refer children to the AEA for further evaluations when Development Assessment of Young Children (DAYC) scores show significant delays in development.

The child health service coordinator will refer children to the AEA for audiologist evaluations.

Child health contract agencies will participate in state monitoring and quality assurance activities.

It is recommended that Early ACCESS agencies have an Internet connection of DSL or better; an operating system of Windows XP or Vista; for MAC users, 10.4 or better; and an Internet browser of FireFox Version 3 or Internet Explorer.

**Local
Childhood
Lead
Prevention
Program
expectations**

All children with a venous blood lead level greater than or equal to 20 µg/dL will be offered the Early ACCESS service option by the lead program case managers.

Parents will be informed their child is at increased risk for developmental delay since his/her blood lead level is greater than or equal to 20 µg/dL. The recommendation will be made for the development of the child to be evaluated by an Early ACCESS professional.

If the family agrees to the referral, the lead program case manager will

make referrals for Early ACCESS developmental evaluation and assessment for children with a venous blood lead level greater than or equal to 20 µg/dL directly to the child's county child health contract agency. It is not necessary to obtain a signature from the family.

Referral forms will be faxed to the child health Early ACCESS service coordinator. Referrals should be made as soon as possible following the visit or inspection of the home. The referral will include family demographic and contact information. It will also include a summary of the initial visit/inspection that includes which hazards were found. This will allow service coordinators to be able to reinforce recommendations from local lead programs, which may include attention to lead hazards.

Recommendations may be made to the family by the lead program case managers. This might include hand washing, housekeeping and improving the child's nutrition.

Observations may be made by the lead program case managers during their initial visit(s). This might include the family's living situation, the child's behavior, interaction between the parent(s) and child, etc.

Lead program case managers will be invited to attend IFSP meetings and have input in the development of the child's IFSP.

**Area
Education
Area
expectations**

The Area Education Agency (AEA) will forward all new referrals of children with a venous blood lead level that is greater than or equal to 20 µg/dL to the appropriate child health service coordinator in a timely manner (within 2 business days).

The AEA will accept the DAYC tool as a comprehensive diagnostic evaluation tool and reevaluate specific domains as deemed appropriate.

The AEA will accept referrals from the child health service coordinator for further evaluations when the child's DAYC results show concern. Further evaluations will be scheduled in a timely manner (within 30 calendar days).

The AEA will accept referrals from the child health service coordinator for audiologist evaluations.

Post-IFSP audiologist evaluations will be scheduled in a timely manner (within 30 calendar days). Pre-IFSP audiologist evaluations will be

scheduled at an expedited degree (in order to meet the 45 day timeline).

The AEA will work with the child health service coordinator to determine which agency is the most appropriate service coordinator for the child and family.

The AEA will cooperate with the child health service coordinator to locate community resources for children enrolled in Early ACCESS.

The AEA will assume responsibility of transition planning for children who are referred to Part B services at two years and three months of age.

The AEA will be the keeper of the official file after a child exits the system.

The AEA will enter all information into IMS.

The AEA will invite the child health service coordinator to appropriate meetings and trainings.

The AEA Early ACCESS regional liaison/coordinator will provide child health service coordinators with peer support rather than supervision and monitoring.

The AEA will communicate with the Iowa Department of Public Health Early ACCESS liaison to resolve system barriers to successful implementation.

Contractor Commitment

Contract requirements

Child health contract agencies must provide Early ACCESS service coordination throughout the agency's service area for children from birth to three years old with a reported venous blood lead level of 20ug/dL.

CH contract agencies must comply with quality assurance activities that include, but are not limited to, AEA chart audits and AEA family surveys.

CH contract agencies must comply with the federal law requiring Early ACCESS services be provided in the child's natural environment (home visits, child care, etc.).

Modifications to the previously approved Early ACCESS service

coordinator's job description must be submitted to the IDPH Early ACCESS coordinator for review and approval.

CH contract agencies must also have plans for implementing service coordination for follow up to positive results of newborn screenings.

CH contract agencies are expected to collaborate with Early ACCESS partners in their service area.

Child health contract agencies are obligated to provide the following federally required services for eligible children and families, at no cost to the family, through IDEA Part C:

- Service coordination
- Participation in multidisciplinary evaluations to determine eligibility
- Development and reviews of Individualized Family Service Plans (IFSP)

Child health contract agencies must participate in the Early ACCESS system. CH contract agencies are required to:

- Provide information to families and colleagues about Early ACCESS/ IDEA Part C. Refer children to Early ACCESS within two days of identification
- Utilize Early ACCESS statewide public awareness materials
- Promote and utilize the toll-free central referral line (Early ACCESS Iowa 1-888-IAKIDS1)
- Upon referral to another Early ACCESS grantee, provide all screening documentation as soon as possible, consistent with appropriate policies on release of health care information covered under confidentiality for patient medical records
- If a referral is not accepted to Early ACCESS, follow-up with the family to determine if advocacy and/or an appeal is necessary on the child's behalf or if the family/child should be linked to other services
- Develop recognition of the two options of eligibility for Early ACCESS services:
 - Experiencing a 25 percent or more delay in one or more areas of development, or
 - Having a high probability of later delay due to a known or other condition based on informed clinical opinion
- Maintain an updated listing of community resources
- Assure public health is represented in Early ACCESS regional level planning activities, including the interagency regional council, if one exists in your area
- Participate with the regional Early ACCESS grantee in developing strategies for educating hospital pediatric and birthing center staff about the Early ACCESS system and referral process

- Provide updated information on Title V services through direct communication to providers and consumers
- Contribute information to the Individualized Family Service Plan (IFSP) consistent with appropriate policies on release of health care information covered under confidentiality for patient medical records
- Establish a communication link, with the family's permission, with other providers working with the family
- Offer to attend IFSP meetings with the family as their advocate
- Attend required meetings and trainings by Early ACCESS as required by IDPH
- Attend or provide training at Early ACCESS regionally sponsored events
- Assist and give information to Early ACCESS service coordinators in applying for Medicaid, *hawk-i* or other funding streams appropriate for children from birth to three years old
- Assure Early ACCESS service coordination by having personnel in the child health contract agency who are prepared to provide service coordination services as requested and appropriate. Pre-authorization and service coordination training is required of those serving as service coordinators. Supervisors may be required to take separate training
- Participate in Early ACCESS regional activities that are collaborative, interagency service systems based upon state policy and procedures

Staffing requirements

Child health Early ACCESS service coordinators employed by MCH contract agencies will have a bachelor's degree or higher or be a registered nurse.

Job description

Job descriptions for Early ACCESS service coordinators will be reviewed annually at the local level to ensure they are appropriate.

During years when the MCH application process is competitive, MCH contract agencies will be required to submit their Early ACCESS service coordinator job description to the IDPH for review and approval. During non-competitive grant years only changes to the job description will be a required submission.

While individual MCH contract agencies will write their own job descriptions, all job descriptions must include the following:

- Service coordinators provide service coordination as requested and appropriate – going beyond a referral source and participation in an IFSP meeting

- Attend required meetings and trainings by Early ACCESS as required by IDPH
 - Hold a bachelor's degree or higher or be a registered nurse
-

Training requirements

There are five Early ACCESS service coordination training modules. Service coordinators at MCH contract agencies are required to complete modules one and three. They may complete additional modules if desired. Service coordinators work directly with the IDPH Early ACCESS liaison to complete all required training components, listed below:

- Module 1:
 - Federal, State and Local Rules, Regulations and Procedures for the Early ACCESS System
 - IDPH Lead Orientation
- Module 3:
 - The Early ACCESS Process
 - Transition Planning
 - DAYC Developmental Assessment
 - IDPH Policies and Procedures
- Other trainings as identified by competency self-assessment tool

The CH contract agency's program coordinator should notify the IDPH Early ACCESS liaison of any agency staff person needing Early ACCESS training, providing the individual's name and contact information. The IDPH Early ACCESS liaison will contact the CH contract agency staff person directly and provide information for accessing trainings and/or arrange for face-to-face trainings.

Backup/ interim plan requirement

CH contract agencies will have a plan for staff vacancies for the Early ACCESS service coordinator position. This plan may not include AEA coverage of the service area in the absence of a child health Early ACCESS service coordinator. Potential plans may include one or both of the following:

- Assuring that the agency has at least two trained qualified individuals to provide Early ACCESS service coordination
 - Executing an agreement for a subcontract with another MCH contract agency or Child Health Specialty Clinics (CHSC). Identify the specific MCH contract agency or CHSC regional office. Include assurance that staff meets IDPH qualifications for the Early ACCESS service coordinator position.
-

Service

At a minimum, families will receive quarterly home visits with monthly

delivery schedule contact. The DAYC evaluation tool will be administered every six months and referrals will be made for additional evaluations and services as determined necessary.

Developmental screen vs. developmental assessment **Screen:** Should we be concerned about this child’s development? Do they need further evaluation? Screening tools: Ages and Stages, Parents' Evaluation of Developmental Status.

Assessment: This is the “further evaluation.” This will tell us what delays the child has and in what specific areas of development the delays are found. Assessment tool for CH contract agencies: Developmental Assessment of Young Children (DAYC).

Financial Considerations

Funding hierarchy The federal statute is clear that IDEA, Part C funds should be used to facilitate the coordination of payment from a variety of sources – not to be a primary funding source for services. Sec. 303.527 requires that federal IDEA, Part C funds are to be the “payor of last resort.” Congress did not intend to provide federal funds to support another state program; but rather, to provide “glue money” to assist states to tie the variety of existing resources together and fill the gaps.

Federal funding guidelines outline the hierarchy for early intervention services. For Iowa, Medicaid is expected to be billed before Title V dollars and Title V dollars are expected to be used before IDEA, Part C dollars.

Medicaid Child health service coordinators are expected to use Medicaid as the payment source for services whenever possible. The following information summarizes Medicaid guidelines for reimbursing the costs of service delivery:

Services that are covered if medically necessary:

- Service coordination
- Direct services
- Transportation (if written in the IFSP)
- Community provider transition

Services that are not covered (educational):

- IFSP meetings
 - IFSP paperwork
 - Special educational transition
-

To qualify for reimbursement:

- Child must be enrolled in Medicaid
- Services must be Medicaid covered (medically necessary)
- Services must be provided by appropriate staff with required degree and/or license
- Child must have an IFSP and billed services must be on the IFSP

Child health contract agencies have billing options. They may bill activities under EPSDT care coordination activities or they may access Infant & Toddler Medicaid. A comparison of the two reimbursement options is located in appendix A21 of this manual.

An infant and toddler program is eligible to participate in the Medicaid program when it is an agency in good standing under the Infant and Toddler with Disabilities (I&T) Program under Subchapter III of the federal Individuals with Disabilities Education Act. In Iowa, this program is known as “Early ACCESS.”

The provider must agree to remit the non-federal share (39.29%) of the Medicaid payment to the Iowa Department of Human Services. The provider keeps only the federal portion (60.61%).

There are additional requirements when providing Infant and Toddler Medicaid services. CH contract agencies are encouraged to contact the IDPH Early ACCESS liaison if considering this option.

Annual Reporting Requirements

Child health agencies

CH contract agencies will be required to report each year on key Early ACCESS data elements as a part of the MCH/FP year-end report.

These reporting requirements will include the total number of:

- Trained service coordinators for the service area
- Early ACCESS referrals received
- Children that received service coordination
- Referrals that were transferred to the AEA after initial IFPS was written
- Referrals received that the children were already receiving services through the AEA upon referral for lead level
- Referrals received for children over the age of 3
- Referrals that the agency was unable to reach or had moved out of state

Iowa Department of

The Iowa Department of Public Health will be prepared to report each year on Early ACCESS data elements. These reporting elements will

- Public Health** include the total number of:
- Trained service coordinators
 - Early ACCESS referrals received
 - Children that received service coordination
 - Referrals that were transferred to the AEA after initial IFPS was written
 - Referrals received that the children were already receiving services through the AEA upon referral for lead level
 - Referrals received for children over the age of three years
 - Referrals that the agencies were unable to reach or had moved out of state



610 Healthy Child Care Iowa

Authority: Healthy Child Care America – Blueprint for Action, MCHB, 1995; IDPH/DHS Written Agreement, SFY1998-2009

Effective Date: January 19, 2012

Initial Revision

Replaces: 610 - October 2008

Background

Healthy Child Care Iowa (HCCI) is a population-based infrastructure building service of the Title V Maternal and Child Health program administered through the IDPH Bureau of Family Health. Through HCCI, child health contract agencies focus on providing health and safety consultation, technical assistance and training to Iowa early care and education businesses. Child health programs ensure these businesses have access to child health and safety expertise through employing or contracting with a Child Care Nurse Consultant (CCNC). The HCCI campaign includes performance measures and standards to guide the nursing practice of the CCNC in the unique public health setting of early care and education businesses.

Responsibilities of the child health contract agency

The Iowa Department of Public Health seeks to improve the overall health status of children in early care and education settings by increasing the availability of the research-based practice of child care nurse consultation. Child health contract agencies are strongly encouraged to provide at least one half-time individual (0.5 FTE) Child Care Nurse Consultant dedicated to HCCI services. Child health funds may be used to directly pay for CCNCs or support the work of CCNCs paid by other resources. Funding for CCNCs may be accessed through resources other than child health funding. CCNCs will attend quarterly regional meetings convened by the Iowa Department of Public Health. The regional meetings serve as a venue for assuring competent and consistent practice among CCNCs across the state. Child health programs will ensure that CCNCs attend HCCI professional development opportunities.

Special condition CH9 of the MCH contract

Item CH9 of the child health special conditions for the MCH contract states, “The Contractor shall provide leadership for the development of health and safety in child care.” This is accomplished through the following activities:

- Negotiate and sign a written agreement with the regional Child Care Resource and Referral (CCR&R) to promote community collaboration and information sharing
 - Secure funding for CCNC services
 - Assess the provision of CCNC services throughout the service area
 - Develop professional relationships with early care and education businesses
 - Provide structure for services of the CCNC, including the following components:
 - A plan for supervision and monitoring progress on child health activities and service priorities
 - A plan for prioritization of services based on community needs assessment
 - A plan for full integration of the CCNC as a member of the child health team
 - Definition of goals and outcomes for the health and safety of children in early care and education settings in the service area
 - Develop local agency capacity through the following strategies:
 - Integrate activities that promote health and safety in early care and education businesses and continuation of HCCI activities in the child health contract agency's business plan
 - Incorporate public health principles and practices into child care policy and procedure
 - Attend HCCI informational meetings
 - Provide Medicaid or *hawk-i* information to early care and education businesses
 - Provide or ensure access to health care services for children attending early care and education who need well-child health care through a medical or dental home and provide care coordination services to families
 - Develop a contingency plan for future vacancies to ensure continuity and access to child care nurse consultation services
-

**Special
condition
CH10 of the
MCH contract**

Item CH10 of the child health special conditions for the MCH contract states, "The Contractor may employ or contract with a CCNC to improve the overall health status of children enrolled in child care." Research indicates that utilizing a Child Care Nurse Consultant is effective in improving the health status of children enrolled in early care and education settings. When employing or contracting with a CCNC the child health contract agency will:

- Ensure the registered nurse hired for the position has a current Iowa license in good standing, and is a Bachelor of Science in Nursing or higher degree prepared, or has a minimum of two years

- of recent experience as a Registered Nurse in community health or pediatric practice
- Ensure the registered nurse is proficient at operating computer hardware and software including desktop and handheld computers, mobile devices, Microsoft Office Suite applications, browsing and researching information on the Internet, taking online courses, attending webinars, uploading and attaching documents to email and other mainstream technology
 - Ensure the registered nurse completes the Iowa Training Project for Child Care Nurse Consultants, based on the national child care health consultation curriculum (National Training Institute for Child Care Health Consultation, University of North Carolina, School of Public Health, Chapel Hill, NC) with specific information on working with Iowa early care and education businesses within the first year of the assignment
 - Participate in the periodic regional and/or statewide child care nurse consultant meetings and continuing education opportunities convened by the Iowa Department of Public Health
 - Provide health and safety education based on the needs of early care and education providers. When providing group health and safety education, the CCNC will use approved training curricula and/or approved training organizations for early care and education providers and follow the guidelines for training credit outlined by the Iowa Administrative Code
 - Provide technical assistance and onsite consultation
 - Conduct assessments, planning, interventions and evaluation with early care and education businesses through nurse consultation
 - Provide peer mentoring and precepting to new Child Care Nurse Consultants to support the infrastructure of Healthy Child Care Iowa when requested by HCCI and as resources allow
 - Maintain a client record for each early care and education business and document nursing assessments, planning, interventions, evaluation and consultation activities
 - Provide the full array of assessments, professional development opportunities, nursing interventions and evaluation activities available from Healthy Child Care Iowa based on the needs of early care and education providers in the service delivery area
 - Adhere to the Child Care Nurse Consultant Role Guidance from the Iowa Department of Public Health, Healthy Child Care Iowa campaign



611 Immunization Program

Authority: Iowa Administrative Code 641 IAC 7.1-7.10; IAC 641 IAC 76.11(135); Federal Register Vol. 53 No. 102, May 26, 1988, PP 19044 – 19045; 42CFR Part 110
Effective Date: January 19, 2012
Initial Revision
Replaces: 611—October 2008

Overview

Children should be screened for their immunization status at each of their child health visits. Children whose immunizations are not up-to-date should receive the necessary vaccines as soon as possible according to the most current *Recommended Childhood and Adolescent Immunization Schedule*. The immunization schedule is approved by the Advisory Committee on Immunization Practices (ACIP), American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). A copy of the most current immunization schedule may be accessed on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/vaccines. MCH contract agencies not directly administering immunizations should screen children for their immunization status at each of their child health visits. If immunizations are needed, the child should be directed to sites that provide immunization services.

Program emphasis

Program emphasis is placed on the following activities:

- Providing barrier-free access to immunization services (such as accepting clients with no appointments (walk-ins) and/or providing immunizations in conjunction with other services such as WIC or lead screenings)
- Conducting reminder and/or recall phone calls to ensure patients return for additional immunizations on time
- Offering several options to receive vaccines
- Providing on-going immunization education and information to the public and health care professionals
- Maintaining a central registry for immunization records when providing immunization or screening services

Federal law and state

Federal law requires that all providers who administer vaccines

database distribute a copy of the appropriate Vaccine Information Statement (VIS) to the client prior to the administration of any vaccination. Copies of the most current VIS may be obtained from the CDC website at www.cdc.gov/vaccines/pubs/vis/default.htm.

Iowa's Immunization Registry Information System (IRIS) is a computerized tracking system of immunizations for children, adolescents and adults who are seen at a variety of public and private health care provider sites throughout the state. IRIS is able to document and monitor individual immunizations, as well as track primary care providers' vaccine inventory. Any child health contract agency providing immunization services must enroll in IRIS. Immunizations provided as a gap-filling direct care service at a CH contract agency must be documented in the IRIS system.

Questions about IRIS should be directed to the IRIS help desk at 800-374-3958.

Vaccines for Children

The Vaccines for Children (VFC) program was created to help raise childhood immunization levels, especially among infants and young children. This program supplies federally purchased vaccines at no cost to public and private health-care providers throughout the state. The VFC program covers the vaccination needs of children from birth through 18 years of age.

Children eligible to receive VFC-provided vaccines include:

- Children enrolled in Medicaid
- Children who do not have health insurance
- Children who are American Indian or Alaskan Native

In addition, children who have health insurance that does not cover the cost of vaccines are considered to be "underinsured," and are eligible to be seen at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and local public health agencies (LPHAs). The VFC program provides all vaccines recommended by the ACIP.

Patients receiving immunization through the VFC program will not be denied vaccines due to their inability to pay the administration fee or failure to make a donation to the provider.

Child health contract agency responsibility

Child health contract agencies providing immunization services must meet the requirements of both the child health and immunization programs. CH contract agency policies must specify the business relationship between the child health and immunization programs.

Child health contract agencies subcontracting with public health agencies that provide VFC and related immunization services must specify in the written contractual agreement whether or not the public health immunization program is included in the child health program. Refer to policy 202 of this manual for more information on subcontracts.

Additional resources

Resources for further information include:

- IDPH Immunization Program at 1-800-831-6293
 - IDPH website: www.idph.state.ia.us
 - Centers for Disease Control and Prevention website: www.cdc.gov/vaccines
 - Immunization Action Coalition website: www.immunize.org
 - Forms and promotional materials can be obtained from the Health Protection Clearinghouse at www.drugfreeinfo.org.
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612 Healthy Homes/Lead Program

AUTHORITY: IOWA ADMINISTRATIVE CODE EPSDT 441.84, IDPH STATEWIDE PLAN FOR CHILDHOOD BLOOD LEAD TESTING, JANUARY 2004
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 612—OCTOBER 2009

Blood lead testing and analysis

Child health contract agencies are responsible for assuring access to blood lead testing for clients 12 months to six years of age. Beginning in the fall of 2008, all children must show proof of a blood lead test when entering kindergarten. Child health contract agencies track the percent of children who received a blood lead test at ages 9-35 months. Data are made available through the IDPH Bureau of Lead Poisoning Prevention.

The IDPH Bureau of Lead Poisoning Prevention has business arrangements with the University of Iowa Hygienic Laboratory and Linn County Laboratory to cover the cost of lead analysis for non-Medicaid enrolled children. The labs bill Medicaid for the lead analysis for Medicaid enrolled children.

Child health contract agencies have the option of purchasing the Lead Care II, a CLIA waived point of care blood lead analyzer. Use of a Lead Care II allows the child health program to perform blood lead analyses for blood draws. Any child health program using the Lead Care II must have a CLIA certificate of waiver and is required to report the results of all blood lead tests to the IDPH Bureau of Lead Poisoning Prevention at least weekly in an electronic format. Blood lead tests with results of 15 µg/dL or higher require that a venous sample be drawn and sent to a reference lab as a confirmatory test.

Child health contract agencies that purchase a Lead Care II must contact the Bureau of Lead Poisoning Prevention immediately at 800-972-2026 so that bureau staff can work with the agency on the required reporting of all blood lead test results. ESA Biosciences, Inc., the manufacturer of the Lead Care II, provides a template/software package that can be used to produce the electronic report that must be sent to the Bureau of Lead Poisoning Prevention. The following

information must be reported for each blood lead test performed on a Lead Care II:

- Name
- Address (city, state, zip code)
- Date of birth
- Race
- Ethnicity of the patient
- Date of blood lead sample collection
- Sample type
- Blood lead test result
- Name and address of the provider

If a blood lead test result of 15 µg/dL or higher is obtained from a Lead Care II, a venous sample must be drawn and sent to a reference lab, such as the University Hygienic Laboratory in Ankeny. Testing a venous sample with a Lead Care II machine under these circumstances is **not** considered to be a "confirmatory" test.

All blood lead test results greater than or equal to 20 µg/dL must be reported immediately by calling the Bureau of Lead Poisoning Prevention in addition to being included in the weekly report. All blood draws and blood lead tests done for Medicaid children must be billed to Medicaid. The Bureau of Lead Poisoning Prevention has developed a procedure to reimburse CH contract agencies for blood draws and blood lead analyses done for children who are not covered by Medicaid. This procedure is available only to CH contract agencies that are part of a local healthy homes/lead program.

The state or local healthy homes/lead program will refer children with blood lead test results greater than or equal to 20 µg/dL directly to the CH contract agency for Early ACCESS developmental evaluation and assessment. The state or local healthy homes/lead program will recommend that an Early ACCESS professional evaluate the development of the child. Additional information about the Early ACCESS program is located in policy 609 of this manual.

Lead testing required for school entry

Beginning in the fall of 2008, all children must show proof of a blood lead test when entering kindergarten. The purpose of the blood lead testing requirement is to improve the health of Iowa's children. Blood lead testing will

- Facilitate early detection and referral for treatment of lead poisoning
- Reduce the incidence, impact and cost of lead poisoning
- Inform parents and guardians of their children's exposure to lead
- Promote the importance of reducing exposure to lead as an integral

- component of preparation for school and learning
- Contribute to statewide surveillance of childhood lead poisoning

The administrative rules require all schools to send IDPH an electronic list of the children enrolled in kindergarten no later than 60 days after the beginning of the school year. IDPH will match the list of children with the blood lead test database that has been maintained by IDPH since 1992. IDPH will then notify the schools of any children that have not received a blood lead test. IDPH will work with the schools, child health contract agencies, local lead programs and local public health agencies to assure that these children receive blood lead tests. The law provides for a religious exemption and an exemption for children that are at very low risk for lead poisoning. Due to the number of new sources of lead that are continually being identified, IDPH anticipates that very few children will meet the requirements for the exemption due to very low risk of lead poisoning.

Additional information is available on the IDPH Healthy Homes/Lead website:

www.idph.state.ia.us/eh/lead_poisoning_prevention.asp#testing

CH contract agency responsibilities

CH contract agencies are responsible for

- Assuring access to blood lead testing and follow-up services for all child health clients under the age of six years. This activity may be a direct health service, enabling service or a population-based service
 - Building partnerships within the community for identifying children with elevated blood lead levels and preventing childhood lead poisoning. This may be accomplished through such activities as working with Healthy Homes/Lead programs, primary care providers and other community-based child serving entities (like WIC) to assure a seamless system of care for children. This activity is an infrastructure building service
-

Assuring access to blood lead testing and follow up services

Every child ages 12 months to six years enrolled/admitted to the child health program will be tested for lead poisoning. Blood lead testing and follow-up services are part of the Iowa Recommendations for Scheduling *Care for Kids* Screenings. The *Care for Kids* schedule is used by CH contract agencies as the best practice guide for preventive child health services. Blood lead testing follows recommendations of the Iowa Department of Public Health Statewide Plan for Childhood Blood Lead Testing (January 2004). Iowa guidelines recommend high-risk children have the initial test at 12 months of age, additional tests at 18 months and 24 months, and

annual testing to age six years. Low-risk children are to be tested at 12 and 24 months or at older ages if they have not been previously tested. The child's risk classification is determined through the administration of the IDPH Blood Lead Poisoning Risk Questionnaire located in appendix A13 of this manual.

The first step in testing is completion of the IDPH Blood Lead Poisoning Risk Questionnaire with the child's parent or guardian. Next, a blood lead test is completed based on the testing schedule located in appendix A14 of this manual. The child's blood lead level will determine what follow-up services are provided. The continuum of follow-up services varies from care coordination to remind families of the need for annual testing to the most intensive level of in-patient medical services with environmental referral for intervention. Guidelines for detection and management of asymptomatic lead-poisoned children are located in appendix A15 of this manual.

Child health informing activities

All children admitted to the child health program, receiving Medicaid EPSDT Informing Services are informed of the need and importance of blood lead testing. Families will be informed of the risk of lead poisoning due to the age of Iowa housing. Families will also be informed of the payment source for the blood testing. Funds are available from the IDPH Healthy Homes/Lead program to pay for blood lead testing for children who are not covered by Medicaid, *hawk-i* or other insurance. Contact the IDPH Healthy Homes/Lead program at 1-800-972-2026 to find out how to access this funding.

Child health care coordination activities

All families will be offered a referral to a primary care provider (or their medical home) for blood lead testing as part of their periodic preventive child health appointment. If the family does not have a medical home, and the CH contract agency is providing gap-filling direct health services, the CH contract agency performs a blood lead test. The family's need for additional intervention or services will be assessed and intervention taken as determined. CH contract agencies must note in the child health data system (CAREs) the date services were provided, notes related to the service visit and the date for recall for blood lead testing. Reminders must be sent to the family for blood testing based on the recall date.

Building partnerships within the community

CH contract agencies are required to develop or maintain linkages with established local Healthy Homes/Lead programs, primary care providers (medical homes) and other agencies serving children (such as WIC) to conduct child find activities, maintain communication and

coordinate other activities to prevent and detect lead poisoning in children.

Establishment of local Healthy Homes/Lead programs

As specified in the contract, CH contract agencies may use child health funds to develop the capacity for a local Healthy Homes/Lead program in areas where one does not exist in the state. Lead testing is part of population-based services on the MCH pyramid.

CH contract agencies that choose to use Title V funds to establish a local Healthy Homes/Lead program may become eligible for additional funds through IDPH. Before a community can apply for these additional funds, the community must develop an approved plan for implementing the major Healthy Homes/Lead activities (listed below). CH contract agencies that choose to explore the development of a Healthy Homes/Lead program may submit a future application to the IDPH Healthy Homes/Lead program for funding. The amount of funding is dependent upon availability at the time of the application. For more information on how to access Healthy Homes/Lead funding, please call the IDPH Healthy Homes/Lead program at 1-800-972-2026.

Major activities of a local Healthy Homes/Lead program

The local Health Homes/Lead program is responsible for:

- Ensuring that primary care providers conduct blood lead testing as recommended by IDPH and AAP and required by Medicaid.
- Providing medical case management of lead-poisoned children. This includes ensuring that lead-poisoned children receive medical evaluations, treatment for iron deficiency, chelation and follow-up blood lead testing. This also includes providing home nursing visits to families of lead-poisoned children. This also includes referring children to the local MCH contract agency (if 0-3 years old) or AEA (if over 3 years old) for developmental evaluations under the Early ACCESS program.
- Providing environmental case management of lead-poisoned children. This includes conducting environmental investigations for all lead-poisoned children to identify lead hazards, to require the control of these hazards and to follow-up to ensure that the measures needed to control hazards are completed. The local board of health must agree to enforce the requirement that lead hazards be controlled in the homes of lead-poisoned children. In addition, healthy homes/lead programs will be involved in looking for other healthy homes issues such as asthma, mold, radon, smoke alarms, fire hazards, tripping and falling hazards and other hazards.
- Coordinating the medical and environmental case management of lead-poisoned children. This includes cooperation between

medical and environmental program staff and the interaction with private physicians and local public housing authorities or housing rehabilitation agencies. In difficult cases, this may include working with other community agencies such as the Iowa Department of Human Services. Programs will also start to make referrals to other agencies for assistance with other healthy homes issues.

- Conducting data management of blood lead test results, case management data and data regarding other housing hazards. This includes using Strategic Tracking of Elevated Lead Levels and Remediation (STELLAR) software as a means of managing surveillance and case management data according to IDPH guidelines and providing required reports to IDPH. In the future, this will involve the use of the web-based Healthy Homes and Lead Poisoning Prevention Surveillance System (HHPSS).
- Providing education and outreach to the community. This includes providing information on healthy homes and childhood lead poisoning to the community through one-on-one visits, informational presentations, interviews with the media and distribution of printed materials.
- Involving the community in solving healthy housing and lead poisoning problems. This includes establishing a coalition for the program. The coalition should be composed of physicians, nurses, housing officials, parents, contractors and representatives of neighborhoods where homes are being renovated. The coalition may be a subgroup/work group of a larger coalition or group such as Safe Kids, Early Childhood Iowa or Decategorization.

Example of five-year plan for Healthy Homes/Lead program development

For a county that is not currently part of a local Healthy Homes/Lead program, the following is an example of a five-year plan to start a program.

Year 1 – Work with primary care providers to assure that blood lead testing is available in the community and that all children under the age of six years are tested for lead poisoning.

Year 2 – Convene a community group to discuss the healthy homes/lead problems and to determine which community organizations are interested in participating in a program.

Year 3 – Determine which community organizations and staff will conduct medical case management for healthy homes/lead problems. Determine which community organizations and staff will conduct environmental case management for healthy homes/lead problems. Determine the lead organization for data management. Develop plan for coordination among organizations.

Year 4 -- Work with local boards of health to develop regulations or to use the general authority of the board of health to require hazards to be repaired in the homes of lead-poisoned children. Send inspectors to six days of training needed to become certified as elevated blood lead (EBL) inspectors and complete EBL agency certifications. Complete training on medical case management of lead-poisoned children. Develop plan for education and outreach. Obtain healthy homes training. Develop a network of referral for healthy homes issues.

Year 5 – Receive funds from IDPH Healthy Homes/Lead program for start-up of program. Purchase equipment. Complete training in STELLAR or HHLPSS and implement STELLAR or HHLPSS for data management.

Child health contract agency responsibility

Child health contract agencies that choose to develop a Healthy Homes/Lead program must meet the requirements of both the child health and Healthy Homes/Lead programs. CH contract agency policies must specify the business relationship between the child health and Healthy Homes/Lead programs. Child health contract agencies subcontracting with public health agencies that provide Healthy Homes/Lead programs must specify in the written contractual agreement whether or not the Healthy Homes/Lead program is included in the child health program. Refer to policy 202 of this manual for more information on subcontracts.

Additional resources

IDPH Healthy Homes/Lead program website:
www.idph.state.ia.us/eh/lead_poisoning_prevention.asp

Screening Young Children for Lead Poisoning: Guidance for State and Local Health Officials, Centers for Disease Control and Prevention 1997.

Screening for Elevated Blood Levels. American Academy of Pediatrics, June 1998.



613 Children’s Health Care Coverage: *hawk-i*

AUTHORITY: SEE AUTHORITY REFERENCE IN TEXT
 EFFECTIVE DATE: JANUARY 19, 2012
 INITIAL REVISION
 REPLACES: 613 – OCTOBER 2008

Overview

Healthy and Well Kids in Iowa (*hawk-i*) is a program for uninsured children that provides no-cost or low-cost health care coverage to children in working families. The *hawk-i* program is financed by federal and state funds and is administered by the Iowa Department of Human Services. *hawk-i* was implemented in 1999 as part of Title XXI of the Social Security Act.

Children enrolled in *hawk-i* receive health insurance through the health plans that participate in the program. Health plans options are available in all of Iowa’s 99 counties. An updated document comparing each of the health plan benefits can be found on the *hawk-i* website at www.hawk-i.org.

Eligibility (must meet all criteria)

- Be under 19 years old
- Be uninsured
- Be ineligible for Medicaid
- Be a citizen or lawful permanent resident alien
- Meet the income guidelines

Covered services

The following services are covered under <i>hawk-i</i> :
• Chiropractic care
• Dental care
• Doctor visits
• Emergencies
• Hearing services
• Hospital care
• Mental health/substance abuse services

• Prescriptions
• Speech therapy
• Surgery
• Vaccines/Shots
• Vision exams
• Well-child visits

Determining eligibility and cost

hawk-i covers families up to 300 percent of the federal poverty level (FPL). Income guidelines are available on the **hawk-i** website, www.hawk-i.org, to see if the children may qualify for free or low-cost health care coverage.

Depending on income, some families pay nothing while others may pay \$10.00-\$20.00 per child per month. However, no family pays more than \$40.00 per month regardless of the number of children in the family who are enrolled. Those assisting families should not try to screen a family for eligibility. It is best to have the family apply and let the **hawk-i** program determine eligibility. If a family's income is below the amounts listed in the charts on the website, their children may qualify for Medicaid.

Additional information about the **hawk-i** application process can be found in policy 316 of this manual.

How long can children get hawk-i?

There is no time limit as long as children are eligible. When an application is approved, the child will be enrolled for 12 months. If the child turns 19, or is no longer eligible for another reason, **hawk-i** will end before the 12 months have passed. **hawk-i** coverage must be renewed every year. Families will get a renewal form before the 12 months have passed. Families need to make sure to send the renewal form back to see if **hawk-i** coverage can continue.

For other questions concerning the **hawk-i** program, call **hawk-i** customer service at 1-800-257-8563 or visit the website at www.hawk-i.org.

hawk-i grassroots outreach

All child health contract agencies must designate an outreach coordinator for **hawk-i** to provide grassroots outreach. The outreach coordinator serves as the single point of contact for ongoing outreach and enrollment activities. The outreach coordinator is responsible for communication with the statewide **hawk-i** outreach coordinator located at the Iowa Department of Public Health.

Outreach efforts must focus on potential partnerships in four key areas: schools, health care providers, faith-based organizations and special/vulnerable populations. CH contract agencies with a population of Native American families in their service delivery area are encouraged to address specific outreach activities for this population. Each CH contract agency is responsible to assure that **hawk-i** outreach activities, including informational materials, are consistent with the Iowa Department of Human Services' approved activities and materials. All CH contract agencies are encouraged to collaborate with and seek cooperation between community stakeholders.

Participation in the statewide Outreach Task Force and attendance at meetings is required for all designated outreach coordinators. Outreach Task Force meetings are held two times per contract year.

Reports required for **hawk-i** outreach activities include:

Report	Copies	Due Date
Quarterly Progress Reports	Four Submitted to SharePoint Service Contract Center	30 th of the month following the end of quarter
Monthly Expenditure Report	Submitted to SharePoint Service Contract Center	15 th of the following month
Year-end Expenditure Report	One	Annually on November 1

Section 700

Oral Health Services

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701 Maternal and Child Oral Health Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]; IOWA ADMINISTRATIVE CODE 641 IAC 50 (135)
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 701 - OCTOBER 2008

Overview

Maternal and Child Health (MCH) contract agencies are responsible for ensuring access to dental services, with an emphasis on early intervention and preventive oral health care beginning at or near the age of 12 months and into adulthood.

Through the core public health functions of assessment, policy development and assurance, contract agencies should work to develop comprehensive oral health service systems by:

- Building community infrastructure for oral health
- Providing population-based dental services
- Providing enabling services to assure access to dental care
- Providing gap-filling direct services

An MCH contract agency may provide all or part of these services based on the community needs assessment and as specified in the approved application plan on file with the IDPH.

Bureau of Oral and Health Delivery Systems, Oral Health Center staff are available upon request to provide consultation and technical assistance for MCH contract agencies.

Iowa Administrative Code

The *Iowa Administrative Code* (IAC) 641 IAC 50 describes the purpose and responsibilities of the state oral health program and dental director. Chapter 641 IAC 50 rules can be found at www.legis.state.ia.us/IAC.html



702 MCH Oral Health Funding

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT
TITLE V SEC 506 [42 USC 706]
EFFECTIVE DATE: OCTOBER 16, 2012
INITIAL REVISION
REPLACES: 702 – JANUARY 2012

Overview

Oral health program funding is available for CH contract agencies to be used for the development of oral health service systems and should be allocated according to an agency needs assessment. Limited funding is also available for MH agencies. The types and allowable use of funds are listed below.

CH-Dental funding

CH-Dental grant funds may be used for the following:

- Costs associated with infrastructure building activities to provide support for the development and maintenance of comprehensive oral health service systems; or
 - Costs associated with direct dental services provided by approved CH agency professional staff (dental hygienists, nurses, nurse practitioners, physician assistants) to Title V eligible children from birth through 21 years of age; or
 - Reimbursement, at Title XIX approved rates, to local dentists providing a limited level of preventive or restorative dental care to Title V eligible children from birth through 21 years of age. (Funding may not be used to support direct care services provided within federally qualified health center (FQHC) dental clinics.)
-

**I-Smile™
funding**

I-Smile™ Grant funds may be used for the following:

- Costs associated with infrastructure-building, population-based, and enabling services to develop local systems to assure a dental home for Medicaid-enrolled children.
 - Cost associated with maintaining a dental hygienist as an I-Smile™ coordinator. The coordinator will be responsible for implementing the agency's I-Smile™ project and will ensure integration and completion of I-Smile™ strategies within the oral health program plan.
-

**Maternal oral
health
funding**

There is no Title V oral health-specific funding for MH contract agencies. However, Title V MH grant funds may be used for infrastructure building, population-based, enabling and direct care services. In addition, some MH services may be available as part of the CH contract agency I-Smile™ program.

**Fee-for-
service and
Medicaid
revenue**

MH and CH agencies must bill IDPH for allowable dental care coordination services provided to clients.

MH and CH agencies must bill Medicaid for allowable oral health services from a qualified provider to Medicaid-enrolled children and eligible MH clients.

Fee-for-service and Medicaid billing must be based on agency costs. The MCH Cost Analysis Report, which includes maternal and child oral health services, must be submitted to IDPH annually.

**Other funding
sources**

MH and CH agencies are encouraged to seek other funds (e.g., Early Childhood Iowa (ECI), foundation funding, community grants) to enhance oral health service systems. Possible use of these supplemental funds may include: reimbursing dentists for treatment for eligible clients; contracting with an agency dental hygienist or nurse to provide oral screenings and fluoride varnish for clients; oral health promotion; or purchasing oral health supplies for clients.



703 The I-Smile™ Program

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B
 EFFECTIVE DATE: JANUARY 19, 2012
 INITIAL REVISION
 REPLACES: 703 - OCTOBER 2008

Background

In 2005, the Iowa legislature mandated that all Medicaid-enrolled children age 12 and under have a designated dental home and be provided with dental screenings and preventive, diagnostic, treatment and emergency services as identified in the oral health standards under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The I-Smile™ program was developed in response to this mandate and serves as the comprehensive program to improve the oral health of Iowa children.

Program overview

The basis of I-Smile™ is a conceptual dental home, with a focus on prevention and care coordination. The program relies on an integrated health system using different levels of care and different types of providers. Health professionals such as dental hygienists, physicians, advanced registered nurse practitioners, registered nurses, physician assistants and dietitians are part of a network providing oral screenings, education, anticipatory guidance and/or preventive services as needed. Through referrals, dentists provide definitive evaluation and treatment.

Due to their existing network of community partners and health related services for Medicaid-enrolled, uninsured and underinsured children, CH agencies are the center of the I-Smile™ dental home network .

Each CH service area must have one Iowa-licensed dental hygienist as I-Smile™ coordinator. The I-Smile™ coordinator, in conjunction with the child health project director and other applicable staff, is responsible for developing and implementing activities within the service region. These activities are included on an activity worksheet, developed each year through the Title V CH application process.

I-Smile™ activities must be based on the needs and assets of the

service area. All counties served must be regularly assessed to determine available oral health resources as well as gaps in oral health services. Each county within the service area must be involved in the planning process and the plan must assure that children in all counties will be served.

**I-Smile™
coordinator
requirements**

In addition to maintaining an Iowa license to practice dental hygiene, I-Smile™ coordinators are required to work a minimum of 20 hours a week and at least 20 hours a week must be spent on infrastructure building, population-based and enabling services. The I-Smile™ coordinator is the single point of contact for I-Smile™ activities.

I-Smile™ coordinators are required to participate in quarterly IDPH trainings and must also successfully complete the IDPH public health training for oral health professionals

**I-Smile
strategies**

The I-Smile™ coordinator is responsible for implementing the following I-Smile™ strategies to improve the dental support system for underserved children. Examples of potential activities are provided for each strategy.

**Partnerships
and planning**

Participate in community health planning and needs assessments.

Develop partnerships with local public health, dental and medical providers, local boards of health, schools, WIC, Head Start, migrant and community health centers, Iowa's hospital health systems and other programs.

Establish an I-Smile™ referral network.

**Local board
of health
linkage**

Assist in assessment, policy development and assurance of local oral health initiatives.

Participate in local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process.

Coordinate the school screening audit process and report to the local board(s) of health.

**CH agency
staff training**

Provide training and oversight of agency staff involved with oral health services.

Assure consistent oral health education for families.

Agency oral health protocols

Work with CH contract agency staff, particularly EPSDT coordinators, to develop oral health protocols.

Care coordination

Ensure appropriate dental care coordination is completed for children and families.

Improve data tracking systems.

Education for healthcare professionals

Train non-dental primary care providers, such as physicians and nurses, to provide oral screenings, fluoride varnish applications and education.

Train dental providers on how to screen/examine very young children.

Oral screening and risk assessment

Ensure completion of periodic oral screenings, risk assessments and referrals to dentists.

Preventive oral health services

Ensure provision of fluoride varnish applications, prophylaxes, radiographs and/or sealants as gap-filling services.

Additional Information

Refer to the I-Smile™ Oral Health Coordinator Handbook for additional information.



704 Oral Health Infrastructure Building Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 704 - OCTOBER 2008

Overview

Infrastructure building services are the foundation for assuring that children, pregnant women and families have access to oral health care.

Infrastructure building activities improve oral health status through the development and maintenance of comprehensive health services systems. These systems include community planning and assessment, policy development and support, training and data system development.

Examples

MCH contract agencies should provide infrastructure building services based on community needs assessments. Examples of infrastructure building activities include:

- Surveying dental offices to identify oral health care accessibility in the service area
- Establishing regular, personal contact with dentists to advocate for children, pregnant women and families
- Establishing referral tracking systems with local dental offices
- Educating and training physicians on oral health
- Conducting in-service staff trainings to develop oral health education, care coordination and referral protocols
- Establishing relationships with school health staff to assure oral health education and prevention services
- Developing and presenting oral health information for the board of health
- Participating in the local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process
- Conducting strategic planning with local oral health coalitions and other forums to assess community oral health needs
- Planning and implementing activities with community partners for

ORAL HEALTH SERVICES

“Give Kids a Smile Day”

- Sharing oral health information with local organizations with interest in the health of women and children
 - Meeting with child care providers to evaluate and implement oral health programs
 - Coordinating the school screening requirement with local boards of health, schools and providers
 - Promoting early oral health care through hospital delivery centers, pediatricians and/or obstetrician/gynecologists
-



705 Oral Health Population-Based Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 705 - OCTOBER 2008

Description

A population-based approach identifies groups within the community who share common health needs, especially low-income families or families with limited availability of health services.

Population-based services allow MCH contract agencies to provide preventive oral health services to an entire group rather than in a one-on-one setting. Programs and services meet the specific needs of these groups, benefiting many people at once. The client's payer source is not assessed and services for individuals are not billed.

Examples

Examples of population-based activities include:

- Oral health education classes for Head Start parents
 - Group oral screenings at a community event (e.g. health fair)
 - Oral health surveys
 - Group oral screenings for the school dental screening requirement
 - Prenatal class education
 - Oral health promotion
-



706 Oral Health Enabling Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 706 - OCTOBER 2008

Overview	Enabling services include outreach, informing and care coordination and provide the support families need to overcome barriers to oral health care. MCH contract agencies are responsible for providing enabling services to all child and maternal health clients regardless of payment source.
<hr/>	
MH outreach	MH agencies will screen pregnant women for access to oral health care coverage. Medicaid presumptive eligibility determinations will be provided for pregnant women without health insurance.
<hr/>	
CH informing	Many families may not understand the importance of early and regular oral health care by age one. As part of informing activities, CH contract agencies will: 1) promote the benefits of preventive oral health care, 2) provide the names and locations of participating dentists, 3) encourage families to establish dental homes; and 4) inform families about available payment sources for oral health care.
<hr/>	
Dental care coordination	Care coordination links pregnant women, children and families to oral health care and requires <u>personal</u> contact (face to face or telephone) with families. Examples of dental care coordination activities include: <ul style="list-style-type: none"> • Assisting clients with locating dentists • Assisting with scheduling dentist appointments • Reminding clients that periodic oral screenings or exams are due • Counseling clients about the importance of keeping appointments • Providing follow-up to assure that oral health care was received • Arranging support services such as transportation, child care or translation/interpreter services

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- Reinforcing anticipatory guidance
- Linking families to other community services (e.g., WIC)



707 Direct Care Oral Health Services Provided by Agency Staff

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]
EFFECTIVE DATE: OCTOBER 16, 2012
INITIAL REVISION
REPLACES: 707 – JANUARY 2012

Description

When gaps in services are clearly identified, MCH contract agencies may provide direct oral health services for families in their service areas. Examples include:

- Oral screenings
- Fluoride varnish applications
- Dental sealant applications
- Prophylaxes
- Radiographs

For the purposes of Medicaid billing, direct services may also include oral health instruction and nutrition and tobacco counseling as it relates to oral health.

Note: An oral screening must always precede the provision of fluoride varnish, dental sealants, prophylaxis or radiographs. Referrals for regular dental care and dental care coordination services must also be provided for women and children receiving direct care services by MCH contract agency staff.

Direct service providers

It is recommended that direct care oral health services be provided by an agency dental hygienist. However, based on an agency needs assessment and workforce availability, registered nurses, nurse practitioners and physician assistants who are employed or contracted by the agency may also provide direct oral health services.

Services must be provided according to IDPH protocols and scope of practice regulations. Training for agency non-dental health professionals must be provided by the CH contract agency I-Smile™ coordinator. The Oral Health Center is also available upon request to provide training materials and technical assistance for MCH contract

agencies.

Documentation of the training, including a list of personnel trained, must be completed on approved form(s) and submitted to the Oral Health Center.

Refer to section 718 of this manual for information on dental hygienist supervision.

Consent for oral health services

MCH contract agencies must assure that consent is obtained prior to performing oral health services to maternal and child health clients according to the following criteria.

Active consent

Active consent is required for:

- Fluoride varnish application
- Dental sealants
- Prophylaxes
- Radiographs

Active consent is also recommended for oral screenings. Active consent means that the client, or parent or guardian of a minor (child under age 18 and unmarried), must indicate consent for each service and must sign and date the form.

Consent forms are valid for one year. Standardized consent forms can be obtained from the Oral Health Center or agencies may develop agency-specific consent forms based on the Oral Health Center template. Consent forms that are modified must be pre-approved by the Oral Health Center.

Combined child or maternal health/oral health consent forms may be used. Specific oral health services offered by the agency must be included on the combined consent forms. MCH contract agencies must assure that all information required on the Oral Health Center consent template is captured within the client chart.

Contract agencies may accept a consent form that has been faxed, but email or phone consent is not acceptable.

Passive consent

Passive (or “opt-out”) consent is an acceptable form of permission for oral screenings, but **is not** acceptable for fluoride varnish application, dental sealants, prophylaxis or radiographs. Passive consent is sometimes used (e.g. school settings) and allows a service to be provided, unless the parent has actively declined the service. Providers must assure that a parent or guardian has been notified about the service and did not decline the service in writing before performing an oral screening.

Note: Agencies are responsible for assuring that all required information is obtained for the purposes of data entry into CARES or WHIS.

MCH contract agency staff or providers with questions about the necessity of obtaining consent, who is authorized to provide consent or the adequacy of a consent form, are encouraged to contact their private legal counsel to obtain advice on such issues.

Refer to sections 300 and 600 of this manual for additional detail on direct services and minor consent requirements.

Release of confidential information

All paper and electronic client records that include information on the identity, assessment, diagnosis, prognosis and services provided to specific individuals or families are considered confidential information. Confidential information may not be shared without a *signed authorization for release*.

Such records can be disclosed only under the circumstances expressly authorized under state or federal confidentiality laws, rules or regulations. MCH contract agencies must have policies and procedures that safeguard the confidentiality of records and may be liable civilly, contractually or criminally for unauthorized release of such information.

The authorized sharing of confidential information benefits the client as well as the MCH program for purposes such as case management, referral, program evaluation or sharing of demographic information.

A separate release of information form and consent form are required for all oral health services provided. However, when direct oral health services are provided in a school setting (parent/guardian not present), a combined consent/release of information form may be used. In this instance, two signatures must be obtained on the form – for consent

and authorizing release of information.

Sample forms may be obtained from the Oral Health Center or agencies may develop agency-specific forms based on the Oral Health Center template.



708 Child Health: Oral Screening and Risk Assessment

AUTHORITY: MEDICAID SCREENING CENTER PROVIDER MANUAL
 EFFECTIVE DATE: JANUARY 19, 2012
 INITIAL REVISION
 REPLACES: 708 - OCTOBER 2009

Descriptions Oral screenings and risk assessments are the first step in determining the level of care a child should receive through the I-Smile™ dental home. The oral screenings and risk assessments:

- Assist in educating families on the need for good oral health
- Determine decay risk and prevention needs
- Identify dental referral needs
- Provide a mechanism to inform dental offices of those needs when scheduling appointments for families.

CH contract agencies that provide complete well-child screens are required to do oral screenings for their clients at each well-child appointment.

CH contract agencies that do not provide complete well-child screens may provide oral screenings and risk assessments as gap-filling services based on a local needs assessment. The screenings can occur at WIC clinics, Head Start classrooms or in other public health settings. The risk assessment should determine the frequency of screenings.

Oral screening components The purpose of an oral screening is to identify oral health anomalies or diseases, such as dental caries, gum disease, soft tissue lesions or developmental problems and to ensure that preventive oral health education is provided. An oral screening includes a medical/dental history and an oral evaluation. Medical or dental history information that cannot be obtained through an interview with the parent or guardian should be collected through the consent form. Each component of the screening, listed below, must be documented in the client paper record and/or CArES.

Medical history

The medical history consists of:

- Name of child's primary care provider
 - Pertinent medical conditions (e.g., special health needs, prematurity/low birth weight)
 - Current medications used
 - Allergies
-

Dental history

The dental history consists of:

- Name of child's dentist
 - Current or recent oral health problems
 - Parental concerns related to child's oral health
 - Frequency of dental visits
 - Home care (frequency of brushing, flossing or other oral hygiene practices)
 - Feeding/snacking habits (exposure to sugar/carbohydrates)
 - Use of fluoride by child (water source, use of fluoridated toothpaste or other fluoride products)
 - Parent or sibling decay history (presence of untreated decay, fillings or crowns)
-

Soft tissue evaluation

The soft tissue evaluation consists of:

- Gum redness or bleeding
 - Swelling or lumps
 - Trauma or injury
-

Hard tissue evaluation

The hard tissue evaluation consists of:

- Suspected decay
 - White spot lesions (demineralized areas) near the gumline
 - Visible plaque
 - Stained fissures
 - Enamel defects
 - Decay history (presence of fillings or crowns)
 - Trauma or injury
-

Dental explorers

Dental explorers should not be used. A visual assessment is sufficient. Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

I-Smile™

Following an oral screening, a risk assessment must be completed on

**risk
assessment**

each child. The risk assessment will establish a child's level of risk for tooth decay as low, moderate or high. Based on the level of risk, the CH contract agency staff will determine one of three appropriate care plans for education, preventive services and referrals to a dentist.

The I-Smile™ Risk Assessment, including the care plan levels, is in the Forms section of the I-Smile™ Oral Health Coordinator Handbook.

**Dental
referrals**

All children that receive a dental screening must be referred to a dentist based on the I-Smile™ risk assessment.

Dental referrals should be documented as a dental service in CAREs according to agency protocol. Service notes about the referral must be entered in CAREs and the client chart as applicable. Follow-up should be provided to ensure that the client's oral health needs have been met.

NOTE: All children must be referred for a dental exam by age 1.



709 School Dental Screenings

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 51 (135)

EFFECTIVE DATE: JANUARY 19, 2012

INITIAL REVISION

REPLACES: 709 - OCTOBER 2008

Overview

All children newly enrolling in an Iowa public or accredited non-public elementary or high school must show proof of a dental screening. This would include students entering kindergarten and ninth grade.

The purpose of the dental screening requirement is to improve the oral health of Iowa's children. The dental screenings will:

- Facilitate early detection and referral for treatment of dental disease
- Reduce the incidence, impact and cost of dental disease
- Inform parents and guardians of their children's dental problems
- Encourage the establishment of effective oral health practices early in life
- Promote the importance of oral health as an integral component of preparation for school and learning
- Contribute to statewide surveillance of oral health

The dental screenings will enhance the I-Smile™ dental home concepts of prevention, education, care coordination and treatment to provide a critical step in closing the gap in access to dental care for underserved children.

Child health contract agency responsibility

I-Smile™ coordinators within each child health contract agency will assist schools, families and local boards of health to assure compliance with the dental screening requirement. Activities may include:

- Distributing forms and dental screening information to schools and dental offices and at community outreach events
- Building partnerships with area dentists and providing care coordination to help children who do not have a dentist
- Training non-dental health care professionals how to provide screenings
- Providing dental screenings in schools and other public health

- settings as a gap-filling service
- Working with schools and board of health to audit dental screening records

Additional information about the school dental screening requirement is available at

www.idph.state.ia.us/hpcdp/oral_health_school_screening.asp



710 Maternal Health: Oral Screening

AUTHORITY: MEDICAID MATERNAL HEALTH CENTER PROVIDER MANUAL
 EFFECTIVE DATE: JANUARY 19, 2012
 INITIAL REVISION
 REPLACES: 710 - OCTOBER 2009

Overview

A healthy mouth is essential for a healthy pregnancy. Diet and hormonal changes that occur during pregnancy may increase a woman's risk for developing tooth decay and gum disease. Oral infections can affect the health of the mother and her baby. Agency staff can have a positive impact on improving the health of maternal health clients and their babies by including oral screening services.

MH contract agencies that provide full prenatal care are required to include oral screening for their clients.

- At least one screening must be completed during the prenatal visit schedule.
- If a client has not seen a dentist following the initial screening, a second screening is required and can be completed postpartum, if needed.

MH contract agencies that do not provide full prenatal care are encouraged to provide oral screenings as a gap-filling service based on local needs assessment.

- Screenings should be considered for all MH clients, especially those who have indicated they have problems with their teeth or gums, or if a health history indicates that the woman is at risk for tooth decay or gum disease.
- Screenings can be provided to MH clients at WIC clinics or in other public health settings.

Oral health screening components

An oral screening includes a medical/dental history and a soft and hard tissue evaluation. The purpose of a screening is to identify dental anomalies or diseases, such as dental caries, gum disease or soft tissue lesions and to ensure that preventive dental education is provided. The screening service must be documented in WHIS and detailed in the client chart.

Medical history

The medical history consists of:

- Name of primary care provider
 - Pertinent medical conditions (e.g., pregnancy due date, prenatal care, nausea/vomiting)
 - Current medications used
 - Allergies
 - Tobacco, alcohol or drug use
-

Dental history

The dental history consists of:

- Name of dentist
 - Current or recent dental problems or injuries
 - Length of time since last dental visit
 - Home care (frequency of brushing, flossing or other oral hygiene practices)
 - Snacking / eating habits (exposure to sugar/carbohydrates)
 - Fluoride use (source of water, use of fluoridated toothpaste or other fluoride products)
-

Soft tissue evaluation

The soft tissue evaluation consists of:

- Gum redness, bleeding or exudate
 - Swelling or lumps
 - Trauma or injury
 - Recession
-

Hard tissue evaluation

The hard tissue evaluation consists of:

- Suspected decay
 - White spot lesions (demineralized areas) near the gumline
 - Plaque, calculus (tartar) or stain
 - Enamel defects
 - Decay history (presence of fillings or crowns)
 - Trauma or injury
 - Loose or missing teeth
-

Dental explorers

Dental explorers should not be used. A visual assessment is sufficient. Using a dental explorer may transfer decay-causing bacteria from one tooth to another or cavitate a demineralized area.

Education

Oral health education should be provided and based on the findings of the oral screening and each MH client's individual need. Education

should include infant oral health care. Refer to policy 715 of this manual for additional information about education resources.

Dental referrals

Following an oral screening, the provider should determine an appropriate care plan for preventive services and referrals to a dentist based on the Maternal Oral Health Risk Assessment. At a minimum, a client should visit the dentist at least once during pregnancy.

Dental referrals must be documented in WHIS and the client's chart as applicable. Follow-up should be provided to ensure completion of the referral.



711 Dental Referrals

AUTHORITY: MEDICAID PROVIDER MANUALS (SCREENING CENTER AND MATERNAL HEALTH CENTER)
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 711 - OCTOBER 2009

Child health referrals

An important goal of the I-Smile™ program is to assist families in obtaining necessary oral health care for their children. Visits to a dentist should begin by the age of one year and continue periodically as indicated by the client's I-Smile™ Risk Assessment and Care Plan.

These visits are important for prevention and early diagnosis of tooth decay and for anticipatory guidance for parents.

Maternal health referrals

Dental care is safe and effective during pregnancy. Ensuring that mothers have direct access to preventive care and treatment is significant for improving both the mother's and child's oral health and overall health.

Dental referrals for MH clients should be based on the Maternal Oral Health Risk Assessment and Care Plan. At a minimum, a MH client should visit the dentist at least once while pregnant. A dental visit should be scheduled as soon as possible if the client has any of the following conditions:

- No dental visit within the past year
- Suspected or obvious decay
- Gum inflammation or abscess
- Pain or injury
- Other abnormalities

Needed treatment can be provided throughout pregnancy; however, the second trimester (14th-20th week) is ideal.

Documentation

Dental referrals should be documented in CARES or WHIS and the client's chart as applicable. Follow-up should be provided to all clients to ensure completion of the referral.



712 Fluoride Varnish

AUTHORITY: NOT APPLICABLE
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 712 - OCTOBER 2008

Overview

Fluoride varnish is highly effective in preventing decay and re-mineralizing white spot lesions. It is recommended for use on at-risk children as soon as teeth begin to erupt. It can also be highly effective for preventing tooth decay in pregnant women.

The benefits of fluoride varnish make it extremely useful within public health programs. When applied to teeth, fluoride varnish sets upon contact with saliva. The hardened layer of fluoride is then absorbed into enamel. If not brushed off the teeth, it will continue to be absorbed for several hours. The absorption time is much longer than for traditional fluoride gels and foams. Fluoride varnish application is recommended two - three times a year.

Because of the hardening and small amount used, the risk of ingestion and toxicity of fluoride varnish is extremely low, making it safe for very young children and pregnant women.

Criteria

The criteria for application of fluoride varnish include:

- Suspected tooth decay
- White spot lesions
- Visible plaque
- History of decay (fillings or crowns)
- Low socio-economic status

Fluoride varnish application must be done in conjunction with an oral screening and must be provided according to the IDPH Fluoride Varnish protocol. Fluoride varnish application must be documented in CARES or WHIS and the client record. The client paper record must include the product used and fluoride concentration.

Reference IDPH website for fluoride varnish protocol:
www.idph.state.ia.us/hpcdp/oral_health.asp



713 Dental Sealants

AUTHORITY: IOWA ADMINISTRATIVE CODE 650 IAC 10
 EFFECTIVE DATE: JANUARY 19, 2012
 INITIAL REVISION
 REPLACES: 713 - OCTOBER 2008

Overview

Dental sealants are an important preventive service for low-income, uninsured and/or underinsured children and adolescents. Based on community needs, a CH agency may provide dental sealant application as a gap-filling service.

Sealants are often applied in a school-based setting, offering an excellent opportunity for collaboration with local schools and dental providers. School settings allow for a large number of children to receive preventive care. IDPH recommends that sealant programs target those schools with a 40 percent or higher free and reduced lunch rate to reach students at highest risk.

The teeth most at risk of decay, and therefore most in need of sealants, are the first and second permanent molars. These teeth should be a priority on all children and adolescents and should be sealed as soon as possible after eruption. This would include children ages 6-8 years and 12-14 years. The permanent premolars and primary molars may also benefit and sealant application on those teeth can be determined on an individual basis.

Clients who receive sealants provided by MCH contract agencies within direct care clinics and/or school-based settings must also be referred for regular dental care and may be eligible for dental care coordination services.

Information on school-based sealant programs can be found at www.idph.state.ia.us/hpcdp/oral_health_school_sealant.asp

Professional qualifications

A client must first have an exam or an oral screening to determine which teeth will benefit from the application of dental sealants. The following professionals are able to do this:

- Iowa-licensed dentist

- Iowa-licensed dental hygienist practicing under public health supervision, with a collaborative agreement that includes sealant screenings

Based on the findings from the exam or screening, a dentist or dental hygienist may apply dental sealants. A dental hygienist must have a collaborative agreement that includes sealant application.

Dental assistants are recommended to be used to assist dentists and/or dental hygienists with sealant application. Dental assistants must be registered with the Iowa Dental Board. Other primary care providers (e.g. nurses) or laypersons (e.g. parent volunteer) are not eligible to serve in this role, per Iowa Dental Board rules.

Periodic retention checks are recommended for quality assurance.

**Documentation
of service**

Sealant application must be documented in CARES or WHIS and the client record. The client paper record must include the sealant product used, tooth number and tooth surface.



714 Prophylaxes and Radiographs

AUTHORITY: IOWA ADMINISTRATIVE CODE 650 IAC 10
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 714 - OCTOBER 2008

Prophylaxes

Based on a community needs assessment, MCH contract agencies may choose to provide prophylaxes (professional cleanings) as a gap-filling service. If a prophylaxis is provided, a periodontal assessment must be part of this service. The documentation for this assessment should include charting that details an evaluation of the teeth, gingiva and periodontium.

A prophylaxis may only be provided by a dentist or a dental hygienist. Dental hygienists must work under general or public health supervision. With general supervision, a dentist must first examine the client and determine a need for the prophylaxis. For dental hygienists working under public health supervision, guidelines for prophylaxis services must be detailed in a collaborative agreement.

If your agency has chosen to have dental hygienists scaling teeth, a periodontal assessment should be part of that service

Contractors must document prophylaxes in CARES or WHIS and the client record.

Radiographs

In partnership with local dentists, MCH contract agencies may provide radiographs to assist with client referrals for dental treatment.

Radiographs may be provided by dental hygienist working under general or public health supervision. With general supervision, a dentist must first examine the client and determine a need for the radiographs. For dental hygienists working under public health supervision, guidelines for radiographs must be detailed in a collaborative agreement.

Standing orders must be in place with a specific dentist who will read

the client's radiographs, provide an exam and establish a treatment plan.

Contractors must document radiographs in CARES or WHIS and the client record. The client paper record must include the type of radiograph, number taken and tooth number, if applicable.



715 Guidelines for Oral Health Education

AUTHORITY: NOT APPLICABLE
 EFFECTIVE DATE: JANUARY 19, 2009
 INITIAL REVISION
 REPLACES: 715 - OCTOBER 2009

Overview Oral health education is an integral component of the services provided by MCH contract agencies. Healthy teeth and gums impact overall health, proper nutrition, appearance and speech for both mother and child.

Child health guidelines Parents/caregivers must be educated about a range of age-appropriate oral health topics such as:

- Importance of baby teeth
- First dental visit by age one and periodic visits based on client’s risk assessment
- Proper daily cleaning and monthly “Lift the Lip” techniques
- Risks associated with certain foods and beverages, including bottle and sippy cup habits
- Importance of topical fluoride exposure
- Non-nutritive sucking (fingers or pacifier)
- Teething/eruption patterns
- Risks associated with certain medications (e.g. dilantin or sugary cough syrups for an extended time)

Maternal health agency guidelines Comprehensive services provided by a MH contract agency must include oral health education as an essential part of total health maintenance. Specific oral health issues that may require counseling include:

- Home care
- Dietary habits, including inappropriate snacking and soda pop consumption
- Pregnancy gingivitis
- Morning sickness
- Risks of periodontal disease and link to pre-term labor

- Systemic implications of oral diseases
 - Fluoride
 - Transfer of decay-causing bacteria from mother to child
 - Infant oral health care
-

Educational resources

MCH contract agency staff providing education must be trained by the I-Smile™ coordinator to assure that a consistent message is given to all clients and families. Agencies should provide anticipatory guidance and oral health education to individuals as well as groups to promote optimal oral health. Client education should be individualized and based on the findings of the oral screening and risk assessment. For child health clients, the parent or caregiver should be included in the education and demonstration of brushing and flossing.

The Oral Health Center provides educational brochures and the Center website includes information to guide development of individual education plans, group curriculum or to provide background information. In addition, I-Smile™ coordinators have up-to-date resources, including those provided in the I-Smile™ Oral Health Coordinator Handbook.

The publication, *Bright Futures in Practice: Oral Health* also provides the tools and strategies needed to promote a lifelong foundation for oral health. It is published by the National Center for Education in Maternal and Child Health and may be ordered from:

www.brightfutures.org.

For specific education guidelines, refer to the I-Smile™ Handbook, the Oral Health Center website at

www.idph.state.ia.us/hpcdp/oral_health.asp or the Smile™ website at www.ismiledentalhome.iowa.gov/



716 Documentation of Oral Health Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 716 – OCTOBER 2009

Service documentation

Direct care oral health services and care coordination must be documented in the client's health record, including CArES or WHIS. Service documentation must include:

- Name of client
- Date of birth
- Medicaid number, if applicable
- Date of service
- Place of service
- Medical and dental history
- Findings from the oral screening
- Direct services provided
- Time in/time out for time-sensitive services (e.g., education, care coordination)
- Oral health education provided, including with whom you spoke
- Dental care coordination, including written and verbal dental referrals and referral follow-up
- Medicaments prescribed
- Client plan of care
- First and last name of provider and credentials
- Signature/signature log

CArES and WHIS serve as both permanent dental health records and data systems. Information is analyzed and used to meet federal reporting requirements, for program planning and evaluation and quality assurance evaluation.

Additional records

A paper chart for each client may also be necessary to assure a comprehensive client health record. The Oral Health Center has developed template oral screening forms for MH and CH clients which MCH contract agencies may use as part of a paper chart. The I-

Smile™ Screening form is available in the I-Smile™ Oral Health Coordinator Handbook.

All child health and maternal health records (hard copy and/or electronic) are the property of IDPH. Refer to section 600 of this manual for more information on record maintenance and storage.

For more specific information on CAREs refer to the CAREs User Manual:

www.idph.state.ia.us/hpcdp/common/pdf/CARES_manual.pdf

For more specific information on WHIS, refer to the WHIS User Manual:

www.idph.state.ia.us/hpcdp/common/pdf/family_health/womans_health_system_manual.pdf



717 Medicaid Billable Oral Health Services

AUTHORITY: IOWA ADMINISTRATIVE CODE 441 IAC 84; 42CFR 441.B
EFFECTIVE DATE: JANUARY 19, 2012
INITIAL REVISION
REPLACES: 717 – OCTOBER 2009

Billing

MCH contract agencies must bill for oral health services provided to Medicaid-enrolled clients. All services except care coordination will be billed directly to Medicaid.

Dental care coordination services will be billed to IDPH as fee-for-service.

Oral health direct care services must be gap-filling. MCH contract agency staff providing direct care services must assure they are not duplicating services provided by a dentist.

Note: For Medicaid clients, the Medicaid Eligibility Verification System (ELVS) is available to verify services and should be used when providing those services (e.g. prophylaxis) that have provider frequency restrictions.

Refer to sections 400 and 600 of this manual and the EPSDT Informing and Care Coordination Handbook for additional billing information.

Service providers

All services listed in the table below may be provided by dental hygienists. With the exception of radiographs, prophylaxes and sealants, these services may also be provided by registered nurses, advanced registered nurse practitioners or physician assistants. Dietitians are eligible to provide nutritional counseling.

Refer to section 300 of this manual for information about eligible providers of care coordination.

All non-dental personnel must be trained using an IDPH-approved training before providing and billing for the listed services. Training must be provided by the I-Smile™ coordinator in the service area or

Oral Health Center staff. Documentation of the training, including courses provided and names of the non-dental providers trained, must be furnished to the Oral Health Center before services are provided and/or billed to Medicaid through an MCH contract agency.

Cost analysis MCH contract agencies must bill their cost for providing oral health services. Reimbursement will be paid at the actual cost for services or at the maximum allowable Medicaid rate, whichever is lower. MCH cost analysis reports must be sent to the IDPH each year.

Questions regarding cost reports, forms needed or billing Medicaid for oral health services should be directed to the Oral Health Center at 1-866-528-4020.

Medicaid-billable oral health services table

Code	Service	Frequency
D0120; use DA modifier	Periodic oral screening (Limited to those patients whose caretaker indicates they have not seen a dentist within the previous 6 months)	Every 6 months
D0145; use DA modifier	Oral evaluation <u>and</u> counseling with primary caregiver - for patient under 3 years of age Includes recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and <u>communication with and counseling of the child's parent, legal guardian and/or primary caregiver.</u>	Every 6 months Not to be used for initial screening (CH agency only)
D0150; use DA modifier	Initial oral screening (Also allowed when provider has not seen patient within a 3-year period)	1 time per patient
D0270	Bitewing radiograph - single film	1 time in a 12-month period (dental hygienist only)
D0272	Bitewing radiograph - two films	1 time in a 12-month period (dental hygienist only)
D0274	Bitewing radiograph - four films	1 time in a 12-month period (dental hygienist only)
D1110	Prophylaxis – adult (<i>age 13 and over</i>)	Every 6 months (dental hygienist only)
D1120	Prophylaxis – child (<i>age 12 and under</i>)	Every 6 months (dental hygienist only)
D1206	Topical fluoride varnish - therapeutic application for moderate to high caries risk patients Risk determined using I-Smile™ Risk Assessment	3 times a year, at least 90 days apart
D1310	Nutritional counseling for the control and prevention of oral disease	Every 6 months per 15 minutes, minimum of 8 minutes
D1320	Tobacco counseling for the control and prevention of oral disease	Every 6 months

ORAL HEALTH SERVICES

		per 15 minutes, minimum of 8 minutes (MH agency only)
D1330	Oral hygiene instruction - Hands on demonstration of individualized home care techniques to client or parent/guardian	Every 6 months per 15 minutes, minimum of 8 minutes
D1351	Sealant - per tooth Deciduous molars Permanent bicuspid Permanent first and second molars Up to age 18 or those with a physical or mental disability	1 time per tooth (dental hygienist only) (Replacement sealants may be covered when the patient record documents medical necessity)

IDPH-billable oral health services table

Code	Service	Frequency
T1016	Dental care coordination for both Title V and Medicaid-enrolled clients	Based on documented time-in/time-out. Cannot be billed on the same day as a Medicaid-billable oral health service.



718 Supervision of Dental Hygienists

AUTHORITY: IOWA ADMINISTRATIVE CODE 650 IAC 10 EFFECTIVE DATE: JANUARY 19, 2012 INITIAL <input type="checkbox"/> REVISION <input checked="" type="checkbox"/> REPLACES: 718 – OCTOBER 2009

Overview

Dental hygienists providing direct care services in Iowa must work under the supervision of a dentist. In public health settings, this would include either public health or general supervision.

Public health supervision

The IDPH recommends that all dental hygienists providing direct services through MCH contract agencies use public health supervision. This allows hygienists to provide services in designated public health settings without the patient first being examined by a dentist.

A hygienist must have an Iowa license and a minimum of three years of clinical experience to work under public health supervision. A collaborative agreement between a dentist and a hygienist is required. The agreement delegates what services can be provided, where services will be provided and standing orders for the services. Dentists providing public health supervision are not required to provide future dental treatment to patients served by the hygienist.

While the collaborative agreement allows the supervising dentist and hygienist to list the location of dental records, it is expected that all dental hygienists (employed or contracted) providing services through MCH contract agencies will maintain clinical records within the agency and not at a separate location. All records of patients receiving services associated with a MCH contract agency are the property of IDPH. Refer to section 600 of this manual for additional detail about client records.

A template and sample for a collaborative agreement is found on the Iowa Dental Board website at www.dentalboard.iowa.gov or on the Oral Health Center website at www.idph.state.ia.us/hpcdp/oral_health_resources.asp.

A copy of the collaborative agreement must be on file with the Oral

Health Center. Each dental hygienist is responsible for reviewing the agreement regularly to assure that information is current. If updates are needed, a revised agreement must be sent to the Oral Health Center.

A report of services provided under public health supervision for the calendar year must be filed at least annually with the Oral Health Center. Oral Health Center staff will provide instructions and a report form each year.

General supervision

General supervision is required for a hygienist providing direct services who is not working under public health supervision. The agency must identify a local dentist as the supervising dentist and must provide a copy of a general supervision agreement to the Oral Health Center. A dentist is required to see a patient prior to a hygienist providing sealant, prophylaxis and radiograph services under general supervision.

Detailed rules about dental hygiene supervision may be found on the Iowa Dental Board website at www.state.ia.us/dentalboard/



719 Child Health: Dental Treatment Provided by Dentists

AUTHORITY: IOWA ADMINISTRATIVE CODE 641 IAC 76 (135), SOCIAL SECURITY ACT TITLE V SEC 506 [42 USC 706]

EFFECTIVE DATE: OCTOBER 16, 2012

INITIAL REVISION

REPLACES: 719 - JANUARY 2012

Reimbursing dentists

Child health-dental funds may be used to reimburse dentists for a limited number of basic preventive and restorative dental services, at Title XIX approved rates, for CH clients. (Funding may not be used to support direct care services provided within FQHC dental clinics.)

Client eligibility

Criteria for eligibility are that

- Child is age 0 – 21 years
- Child is not eligible for the Title XIX Program
- Child is uninsured or underinsured for dental coverage
- Child's family meets income guidelines as established by Iowa's Title XXI program

Dental provider agreements

Child Health contract agencies that use contracted dental funds to reimburse dentists for services are required to have a written agreement with those providers.

Recommended information to include in the agreement includes:

- List of the dental procedures that Title V will reimburse and the reimbursement amounts for those procedures
- Maximum amount allowed per child without prior authorization
- Information on how a dental office may request an “exception” to pay for procedures not currently on the list
- Clarification that reimbursement from Title V is accepted as payment in full and the family is not responsible for additional costs
- Summary of the contract agency’s care coordination services, including the I-Smile™ coordinator contact information

Dental vouchers

Child health contract agencies may create a “dental voucher” system for eligible clients. The family can be given a voucher to provide to a participating dental office. The voucher will indicate that the child health contract agency will reimburse the dental office for treatment costs.

Dental vouchers may not be used to pay for direct care services provided within FQHC dental clinics.

For any client receiving oral health services by a dentist reimbursed with CH-dental funds, “dental voucher” must be listed as a service in CARES.

Dental treatment coverage

The Oral Health Center provides MCH contract agencies an updated list of pre-authorized codes and reimbursement levels annually. Reimbursement for services is based on the most current Title XIX fee schedule.

Periodic examinations, prophylaxes and topical fluoride applications may be paid just once per year for a child health client. Payment for dental sealants is allowed for children through age 18. Payment is also allowed just one time per tooth.

Exceptions to the authorized dental treatment coverage must be requested in writing to the Oral Health Center for consideration. Policy 205 of this manual contains directions for requesting an exception to policy.

Quarterly reporting

CH contract agencies are required to submit quarterly dental data reports through SharePoint to the Oral Health Center at the end of each fiscal quarter (January 30, April 30, July 30 and October 30). Information collected includes the number of children using dental funds, the number of dental procedures provided and the total amount of treatment dollars reimbursed to dentists per quarter. Oral Health Center staff will make the dental data report template available through the SharePoint Service Contract Center.

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Appendix A1: Title V of the Social Security Act

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT¹

Sec. 501.	Authorization of appropriations
Sec. 502.	Allotments to states and federal set-aside
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Sec. 507.	Criminal penalty for false statements
Sec. 508.	Nondiscrimination
Sec. 509.	Administration of title and state programs
Sec. 510.	Separate program for abstinence education

Authorization of Appropriations

SEC. 501. [42 U.S.C. 701] (a) To improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the year 2000, there are authorized to be appropriated \$705,000,000 for fiscal year 1994 and each fiscal year thereafter—

- 1) for the purpose of enabling each State--
 - A) to provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services;
 - B) to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;
 - C) to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and
 - D) to provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families;
2. for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance, research, and training with respect to maternal

¹ Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. Title V appears in the United States Code as §§701-709, subchapter V, chapter 7, Title 42. Regulations of the Secretary of Health and Human Services relating to Title V are contained in chapter I, Title 42, and in subtitle A, Title 45, Code of Federal Regulations. See Vol. II, P.L. 78-410, §317A(a) and (d), with respect to coordination required in lead poisoning prevention. See Vol. II, P.L. 88-352, §601, with respect to prohibition against discrimination in federally assisted programs. See Vol. II, P.L. 95-521, §102(i), with respect to reporting of benefits received under the Social Security Act. See Vol. II, P.L. 101-239, §6508, with respect to a demonstration project on health insurance for medically uninsurable children; and §6509, with respect to a maternal and child health handbook.

and child health and children with special health care needs (including early intervention training and services development), for genetic disease testing, counseling, and information development and dissemination programs, for grants (including funding for comprehensive hemophilia diagnostic treatment centers) relating to hemophilia without regard to age, and for the screening of newborns for sickle cell anemia, and other genetic disorders and follow-up services; and

3. subject to section 502(b) for the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for developing and expanding the following—
 - (A) maternal and infant health home visiting programs in which case management services as defined in subparagraphs (A) and (B) of subsection (b)(4), health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified nonprofessional acting under the supervision of a health care professional,
 - (B) projects designed to increase the participation of obstetricians and pediatricians under the program under this title and under state plans approved under title XIX,
 - (C) integrated maternal and child health service delivery systems (of the type described in section 1136 and using, once developed, the model application form developed under section 6506(a) of the Omnibus Budget Reconciliation Act of 1989),
 - (D) maternal and child health centers which (i) provide prenatal, delivery, and postpartum care for pregnant women and preventive and primary care services for infants up to age one, and (ii) operate under the direction of a not-for-profit hospital,
 - (E) maternal and child health projects to serve rural populations, and
 - (F) outpatient and community based services programs (including day care services) for children with special health care needs whose medical services are provided primarily through inpatient institutional care.

Funds appropriated under this section may only be used in a manner consistent with the Assisted Suicide Funding Restriction Act of 1997².

(b) For purposes of this title:

1. The term "consolidated health programs" means the programs administered under the provisions of—
 - (A) this title (relating to maternal and child health and services for children with special health care needs),
 - (B) section 1615(c) of this Act (relating to supplemental security income for disabled children),
 - (C) sections 316 (relating to lead-based paint poisoning prevention programs), 1101 (relating to genetic disease programs), 1121 (relating to sudden infant death syndrome programs) and 1131 (relating to hemophilia treatment centers) of the Public Health Service Act³, and
 - (D) title VI⁴ of the Health Services and Centers Amendments of 1978 (Public Law 95-626; relating to adolescent pregnancy grants), as such provisions were in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act.⁵
2. The term "low income" means, with respect to an individual or family, such an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981⁶
3. The term "care coordination services" means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families.
4. The term "case management services" means—
 - (A) with respect to pregnant women, services to assure access to quality prenatal, delivery, and

² P.L. 105-12, §9(d), added this sentence, effective April 30, 1997.

³ P.L. 78-410. P.L. 97-35, §2193(b)(1), 95 Stat. 827, repealed §§316, 1101, 1121, and 1131 of the PHSA.

⁴ P.L. 95-626, Title VI, was repealed by P.L. 97-35, §955(b); 95 Stat. 592.

⁵ P.L. 97-35, Title XXI, subtitle D [95 Stat. 818]

⁶ See Vol. II, P.L. 97-35

postpartum care; and

Allotments to States and Federal Set-Aside

SEC. 502. [42 U.S.C. 702] (a)(1) Of the amounts appropriated under section 501(a) for a fiscal year that are not in excess of \$600,000,000, the Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a)(2). The authority of the Secretary to enter into any contracts under this title is effective for any fiscal year only to such extent or in such amounts as are provided in appropriations Acts.

2. For purposes of paragraph (1)—

(A) amounts retained by the Secretary for training shall be used to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children; and

(B) amounts retained by the Secretary for research shall be used to make grants to, contracts with, or jointly financed cooperative agreements with, public or nonprofit institutions of higher learning and public or nonprofit private agencies and organizations engaged in research or in maternal and child health or programs for children with special health care needs for research projects relating to maternal and child health services or services for children with special health care needs which show promise of substantial contribution to the advancement thereof.

3. No funds may be made available by the Secretary under this subsection or subsection (b) unless an application therefore has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain and be accompanied by such information as the Secretary may specify. No such application may be approved unless it contains assurances that the applicant will use the funds provided only for the purposes specified in the approved application and will establish such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement and accounting of Federal funds paid to the applicant under this title.

(b)(1)(A) Of the amounts appropriated under section 501(a) for a fiscal year in excess of \$600,000,000 the Secretary shall retain an amount equal to 12 3/4 percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a)(3).

(B) Any amount appropriated under section 501(a) for a fiscal year in excess of \$600,000,000 that remains after the Secretary has retained the applicable amount (if any) under subparagraph (A) shall be retained by the Secretary in accordance with subsection (a) and allocated to the States in accordance with subsection (c).

(2)(A) Of the amounts retained for the purpose of carrying out activities described in section 501(a)(3)(A), (B), (C), (D) and (E), the Secretary shall provide preference to qualified applicants which demonstrate that the activities to be carried out with such amounts shall be in areas with a high infant mortality rate (relative to the average infant mortality rate in the United States or in the State in which the area is located).

(B) In carrying out activities described in section 501(a)(3)(D), the Secretary shall not provide for developing or expanding a maternal and child health center unless the Secretary has received satisfactory assurances that there will be applied, towards the costs of such development or expansion, non-Federal funds in an amount at least equal to the amount of funds provided under this title toward such development or expansion.

(c) From the remaining amounts appropriated under section 501(a) for any fiscal year that are not in excess of \$600,000,000, the Secretary shall allot to each State which has transmitted an application for the fiscal year under section 505(a), an amount determined as follows:

(1) The Secretary shall determine, for each State –

(A)(i) the amount provided or allotted by the Secretary to the State and to entities in the State under the provisions of the consolidated health programs (as defined in section 501(b)(1)), other than for any of the projects or programs described in subsection (a), from appropriations for fiscal year 1981, (ii) the proportion that such amount for that State bears to the total of such amounts for all the States, and (B)(i) the number of low

income children in the State, and (ii) the proportion that such number of children for that State bears to the total of such numbers of children for all the States.

- (2) Each such State shall be allotted for each fiscal year an amount equal to the sum of—
 (A) the amount of the allotment to the State under this subsection in fiscal year 1983, and
 (B) the State's proportion (determined under paragraph (1)(B)(ii)) of the amount by which the allotment available under this subsection for all the States for that fiscal year exceeds the amount that was available under this subsection for allotment for all the States for fiscal year 1983.

(d)(1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505(a) for the fiscal year or because some States have indicated in their descriptions of activities under section 505(a) that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

(2) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(b)(2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

Payments to States

SEC. 503. [42 U.S.C. 703] (a) From the sums appropriated therefore and the allotments available under section 502(c), the Secretary shall make payments as provided by section 6503(a) of title 31, United States Code to each State provided such an allotment under section 502(c), for each quarter, of an amount equal to four-sevenths of the total of the sums expended by the State during such quarter in carrying out the provisions of this title.

(b) Any amount payable to a State under this title from allotments for a fiscal year which remains unobligated at the end of such year shall remain available to such State for obligation during the next fiscal year. No payment may be made to a State under this title from allotments for a fiscal year for expenditures made after the following fiscal year.

(c) The Secretary, at the request of a State, may reduce the amount of payments under subsection (a) by—

- (1) the fair market value of any supplies or equipment furnished the State, and
- (2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the State and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of supplies or equipment or the detail of an officer or employee is for the convenience of and at the request of the State and for the purpose of conducting activities described in section 505(a) on a temporary basis. The amount by which any payment is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment or in detailing the personnel, on which the reduction of the payment is based, and the amount shall be deemed to be part of the payment and shall be deemed to have been paid to the State.

Use of Allotment Funds

SEC. 504. [42 U.S.C. 704] (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation and including payment of salaries and other related expenses of National Health Service Corps personnel) consistent with its application transmitted under section 505(a).

- (b) Amounts described in subsection (a) may not be used for –
- (1) inpatient services, other than inpatient services provided to children with special health care needs or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;
 - (2) cash payments to intended recipients of health services;
 - (3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;
 - (4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
 - (5) providing funds for research or training to any entity other than a public or nonprofit private entity; or
 - (6) payment for any item or service (other than an emergency item or service) furnished—
 - (A) by an individual or entity during the period when such individual or entity is excluded under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or
 - (B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

(c) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this title.

(d) Of the amounts paid to a State under section 503 from an allotment for a fiscal year under section 502(c), not more than 10 percent may be used for administering the funds paid under such section.

Application for Block Grant Funds

SEC. 505. [42 U.S.C. 705] (a) In order to be entitled to payments for allotments under section 502 for a fiscal year, a State must prepare and transmit to the Secretary an application (in a standardized form specified by the Secretary) that--

- (1) contains a statewide needs assessment (to be conducted every 5 years) that shall identify (consistent with the health status goals and national health objectives referred to in section 501(a)) the need for—
 - (A) preventive and primary care services for pregnant women, mothers, and infants up to age one;
 - (B) preventive and primary care services for children; and
 - (C) services for children with special health care needs (as specified in section 501(a)(1)(D));
- (2) includes for each fiscal year—
 - (A) a plan for meeting the needs identified by the state-wide needs assessment under paragraph (1); and
 - (B) a description of how the funds allotted to the State under section 502(c) will be used for the provision and coordination of services to carry out such plan that shall include—
 - (i) subject to paragraph (3), a statement of the goals and objectives consistent with the health status goals and national health objectives referred to in section 501(a) for meeting the needs specified in the State plan described in subparagraph (A);
 - (ii) an identification of the areas and localities in the State in which services are to be provided and coordinated;
 - (iii) an identification of the types of services to be provided and the categories or characteristics of individuals to be served; and

- (iv) information the State will collect in order to prepare reports required under section 506(a);
- (3) except as provided under subsection (b), provides that the State will use—
 - (A) at least 30 percent of such payment amounts for preventive and primary care services for children, and
 - (B) at least 30 percent of such payment amounts for services for children with special health care needs (as specified in section 501(a)(1)(D));
- (4) provides that a State receiving funds for maternal and child health services under this title shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989; and
- (5) provides that—
 - (A) the State will establish a fair method (as determined by the State) for allocating funds allotted to the State under this title among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and follow up with respect to, health care assessments and services financially assisted by the State under this title and methods for assuring quality assessments and services;
 - (B) funds allotted to the State under this title will only be used, consistent with section 508, to carry out the purposes of this title or to continue activities previously conducted under the consolidated health programs (described in section 501(b)(1));
 - (C) the State will use—
 - (i) special consideration (where appropriate) for the continuation of the funding of special projects in the State previously funded under this title (as in effect before August 31, 1981), and
 - (ii) a reasonable proportion (based upon the State's previous use of funds under this title) of such sums to carry out the purposes described in subparagraphs (A) through (D) of section 501(a)(1);
 - (D) if any charges are imposed for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services;
 - (E) the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and title XIX and about other relevant health and health-related providers and practitioners; and
 - (F) the State agency (or agencies) administering the State's program under this title will—
 - (i) participate in the coordination of activities between such program and the early and periodic screening, diagnostic, and treatment program under section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnostic, and treatment services), to ensure that such programs are carried out without duplication of effort,
 - (ii) participate in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX),
 - (iii) participate in the coordination of activities within the State with programs carried out under this title and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs), and
 - (iv) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under

subparagraph (A) or (B) of section 1902(l)(1) and, once identified, to assist them in applying for such assistance.

The application shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.

(b) The Secretary may waive the requirements under subsection (a)(3) that a State's application for a fiscal year provide for the use of funds for specific activities if for that fiscal year—

- (1) the Secretary determines—
 - (A) on the basis of information provided in the State's most recent annual report submitted under section 506(a)(1), that the State has demonstrated an extraordinary unmet need for one of the activities described in subsection (a)(3), and
 - (B) that the granting of the waiver is justified and will assist in carrying out the purposes of this title; and
- (2) the State provides assurances to the Secretary that the State will provide for the use of some amounts paid to it under section 503 for the activities described in subparagraphs (A) and (B) of subsection (a)(3) and specifies the percentages to be substituted in each of such subparagraphs.

Reports and Audits

SEC. 506. [42 U.S.C. 706] (a)(1) Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report shall be prepared by, or in consultation with, the State maternal and child health agency. In order properly to evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall be in such standardized form and contain such information (including information described in paragraph (2)) as the Secretary determines (after consultation with the States⁷) to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds,⁸ (C) to describe the extent to which the State has met the goals and objectives it set forth under section 505(a)(2)(B)(i) and the national health objectives referred to in section 501(a) and (D) to determine the extent to which funds were expended consistent with the State's application transmitted under section 505(a). Copies of the report shall be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

(2) Each annual report under paragraph (1) shall include the following information:

- (A)
 - (i) The number of individuals served by the State under this title (by class of individuals).
 - (ii) The proportion of each class of such individuals, which has health coverage.
 - (iii) The types (as defined by the Secretary) of services provided under this title to individuals within each such class.
 - (iv) The amounts spent under this title on each type of services, by class of individuals served.
- (B) Information on the status of maternal and child health in the State, including—
 - (i) information (by county and by racial and ethnic group) on—
 - (I) the rate of infant mortality, and
 - (II) the rate of low-birth-weight births;
 - (ii) information (on a State-wide basis) on—
 - (I) the rate of maternal mortality,
 - (II) the rate of neonatal death,
 - (III) the rate of perinatal death,
 - (IV) the number of children with chronic illness and the type of illness,

⁷ P.L. 104-316, §122(f), struck out "and the Comptroller General", effective October 19, 1996

⁸ As in original.

- (V) the proportion of infants born with fetal alcohol syndrome,
 - (VI) the proportion of infants born with drug dependency,
 - (VII) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and
 - (VIII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B; and
 - (iii) information on such other indicators of maternal, infant, and child health care status as the Secretary may specify.
- (C) Information (by racial and ethnic group) on—
- (i) the number of deliveries in the State in the year, and
 - (ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.
- (D) Information (by racial and ethnic group) on—
- (i) the number of infants under one year of age who were in the State in the year, and
 - (ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year.
- (E) Information on the number of—
- (i) obstetricians,
 - (ii) family practitioners,
 - (iii) certified family nurse practitioners,
 - (iv) certified nurse midwives,
 - (v) pediatricians, and
 - (vi) certified pediatric nurse practitioners,

who were licensed in the State in the year.

For purposes of subparagraph (A), each of the following shall be considered to be a separate class of individuals: pregnant women, infants up to age one, children with special health care needs, other children under age 22, and other individuals.

(3) The Secretary shall annually transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that includes—

- (A) a description of each project receiving funding under paragraph (2) or (3) of section 502(a), including the amount of Federal funds provided, the number of individuals served or trained, as appropriate, under the project, and a summary of any formal evaluation conducted with respect to the project;
- (B) a summary of the information described in paragraph (2)(A) reported by States;
- (C) based on information described in paragraph (2)(B) supplied by the States under paragraph (1), a compilation of the following measures of maternal and child health in the United States and in each State:
 - (i) Information on—
 - (I) the rate of infant mortality, and
 - (II) the rate of low-birth-weight births.
 Information under this clause shall also be compiled by racial and ethnic group.
 - (ii) Information on—
 - (I) the rate of maternal mortality,
 - (II) the rate of neonatal death,
 - (III) the rate of perinatal death,
 - (IV) the proportion of infants born with fetal alcohol syndrome,
 - (V) the proportion of infants born with drug dependency,
 - (VI) the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy, and

- (VII) the proportion of children, who at their second birthday, have been vaccinated against each of measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Hib meningitis, and hepatitis B.
 - (iii) Information on such other indicators of maternal, infant, and child health care status as the Secretary has specified under paragraph (2)(B)(iii).
 - (iv) Information (by racial and ethnic group) on—
 - (I) the number of deliveries in the State in the year, and
 - (II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year;
- (D) based on information described in subparagraphs (C), (D), and (E) of paragraph (2) supplied by the States under paragraph (1), a compilation of the following information in the United States and in each State:
- (i) Information on—
 - (I) the number of deliveries in the year, and
 - (II) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under a State plan under title XIX in the year. Information under this clause shall also be compiled by racial and ethnic group.
 - (ii) Information on—
 - (I) the number of infants under one year of age in the year, and
 - (II) the number of such infants who were provided services under this title or were entitled to benefits under a State plan under title XIX at any time during the year.

Information under this clause shall also be compiled by racial and ethnic group.
 - (iii) Information on the number of—
 - (I) obstetricians,
 - (II) family practitioners,
 - (III) certified family nurse practitioners,
 - (IV) certified nurse midwives,
 - (V) pediatricians, and
 - (VI) certified pediatric nurse practitioners, who were licensed in a State in the year; and
- (E) an assessment of the progress being made to meet the health status goals and national health objectives referred to in section 501(a).
- (b)(1) Each State shall, not less often than once every two years, audit its expenditures from amounts received under this title. Such State audits shall be conducted by an entity independent of the State agency administering a program funded under this title in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the State shall submit a copy of that audit report to the Secretary.
- (2) Each State shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the State, not to have been expended in accordance with this title and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the State is or may become entitled under this title or may otherwise recover such amounts.
- (3) The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any State which is not using its allotment under this title in accordance with this title. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

(c) The State shall make copies of the reports and audits required by this section available for public inspection within the State.

(d)(1) For the purpose of evaluating and reviewing the block grant established under this title, the Secretary and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents that are related to such block grant, and that are in the possession, custody, or control of States, political subdivisions thereof, or any of their grantees.

(2) In conjunction with an evaluation or review under paragraph (1), no State or political subdivision thereof (or grantee of either) shall be required to create or prepare new records to comply with paragraph (1).

(3) For other provisions relating to deposit, accounting, reports, and auditing with respect to Federal grants to States, see section 6503(b) of title 31, United States Code.

Criminal Penalty for False Statements

SEC. 507. [42 U.S.C. 707] (a) Whoever-- knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payment may be made by a State from funds allotted to the State under this title, or

(1) having knowledge of the occurrence of any event affecting his initial or continued right to any such payment conceals or fails to disclose such event with an intent fraudulently to secure such payment either in a greater amount than is due or when no such payment is authorized, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(b) For civil monetary penalties for certain submissions of false claims, see section 1128A of this Act.

Nondiscrimination

SEC. 508. [42 U.S.C. 708] (a)(1) For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975⁹, on the basis of handicap under section 504 of the Rehabilitation Act of 1973¹⁰, on the basis of sex under title IX of the Education Amendments of 1972¹¹, or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964¹², programs and activities funded in whole or in part with funds made available under this title are considered to be programs and activities receiving Federal financial assistance.

(2) No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title.

(b) Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section 502(c), has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed sixty days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

(1) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted,

(2) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, as may be applicable, or

(3) take such other action as may be provided by law.

(c) When a matter is referred to the Attorney General pursuant to subsection (b)(1), or whenever he has reason to believe that the entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil

9 See Vol. II, P.L. 94-135, Title III [89 Stat. 728].

10 See Vol. II, P.L. 93-112.

11 See Vol. II, P.L. 92-318.

12 See Vol. II, P.L. 88-352

action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

Administration of Title and State Programs

SEC. 509. [42 U.S.C. 709] (a) The Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for—

- (1) the Federal program described in section 502(a);
- (2) promoting coordination at the Federal level of the activities authorized under this title and under title XIX of this Act, especially early and periodic screening, diagnosis and treatment, related activities funded by the Departments of Agriculture and Education, and under health block grants and categorical health programs, such as immunizations, administered by the Secretary;
- (3) disseminating information to the States in such areas as preventive health services and advances in the care and treatment of mothers and children;
- (4) providing technical assistance, upon request, to the States in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation and in developing consistent and accurate data collection mechanisms in order to report the information required under section 506(a)(2);
- (5) in cooperation with the National Center for Health Statistics and in a manner that avoids duplication of data collection, collection, maintenance, and dissemination of information relating to the health status and health service needs of mothers and children in the United States;
- (6) assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under this title from the information required to be reported by the States under sections 505(a) and 506; and¹³
- (7) assisting States in the development of care coordination services (as defined in section 501(b)(3)); and
- (8) developing and making available to the State agency (or agencies) administering the State's program under this title a national directory listing by State the toll-free numbers described in section 505(a)(5)(E).

(b) The State health agency of each State shall be responsible for the administration (or supervision of the administration) of programs carried out with allotments made to the State under this title, except that, in the case of a State which on July 1, 1967, provided for administration (or supervision thereof) of the State plan under this title (as in effect on such date) by a State agency other than the State health agency, that State shall be considered to comply¹⁴ the requirement of this subsection if it would otherwise comply but for the fact that such other State agency administers (or supervises the administration of) any such program providing services for children with special health care needs.

Separate Program for Abstinence Education

SEC. 510. [42 U.S.C. 710] (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

- (1) the amount appropriated in subsection (d) for the fiscal year; and
- (2) the percentage determined for the State under section 502(c)(1)(B)(ii).

(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

¹³ As in original. "and" should probably not appear

¹⁴ As in original. Probably should be "comply with".

- (2) For purposes of this section, the term "abstinence education" means an educational or motivational program which--
- (A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
 - (B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
 - (C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
 - (D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
 - (E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
 - (F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
 - (G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
 - (H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.
- (c)(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).
- (2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.
- (d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional \$50,000,000 for each of the fiscal years 1998 through 2002. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year.¹⁵
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¹⁵ P.L. 104-193, §912, added §510, effective August 22, 1996.

Appendix A2: Iowa Administrative Code 641 (2/6/02)

CHAPTER 76 MATERNAL AND CHILD HEALTH PROGRAM

641—76.1(135)
Program
explanation

The maternal and child health (MCH) programs are operated by the Iowa department of public health as the designated state agency pursuant to an agreement with the federal government. The majority of the funding available is from the Title V, MCH services block grant, administered by the Health Resources and Services Administration within the United States Department of Health and Human Services. The purpose of the program is to promote the health of mothers and children by ensuring or providing access to quality maternal and child health services (especially for low-income families or families with limited availability of health services); to reduce infant mortality and the incidence of preventable diseases and handicapping conditions; to increase the number of children appropriately immunized against disease; and to facilitate the development of community-based systems of health care for children and their families. The program provides and promotes family-centered, community-based coordinated care, including care/service coordination for children with special health care needs. The department's family services bureau enters into contracts with selected private nonprofit or public agencies for the assurance of access to prenatal and postpartum care for women, preventive and primary child health services, and services to children with special health care needs. The types of services provided by these contracts are infrastructure building, population-based services, enabling services, and direct health services. The department's dental health bureau collaborates with the family services bureau to develop oral health programs to reduce barriers to oral health care and reduce dental disease through prevention. The children with special health care needs program is administered by Child Health Specialty Clinics (CHSC), University of Iowa. The department contracts with the University of Iowa department of pediatrics' Child Health Specialty Clinics to provide services to children with special health care needs. In accordance with the Maternal and Child Health Services Title V Block Grant Program administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, CHSC shall ensure that public health funds will be used to cover the cost of services only after all other sources of reimbursement have been exhausted. The MCH advisory council assists in the development of the state plan for MCH, including children with special health care needs and family planning. The advisory council assists with assessment of need, prioritization of services, establishment of objectives, and encouragement of public support for MCH and family planning programs. In addition, the advisory council advises the director regarding health and nutrition services for women and children, supports the development of special projects and conferences and advocates for

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health and nutrition services for women and children. The director appoints the council membership. Membership shall include parents of and service providers for children with special health care needs. The council membership shall also include the chairs, or designees, of the department's advisory committee for perinatal guidelines, and the birth defects advisory committee to ensure coordination of their respective issues and priorities. The chair of the family services bureau grantee committee or the designee of the chair may serve as an ex-officio member of the council.

641—76.2(135)
Adoption by
reference.

Federal requirements contained in the Omnibus Reconciliation Act of 1989 (Public Law 101-239), Title V, MCH services block grant shall be the rules governing the Iowa MCH program and are incorporated by reference herein. The department finds that certain rules should be exempted from notice and public participation as being a very narrowly tailored category of rules for which notice and public participation are unnecessary as provided in Iowa Code section 17A.4(2). Such rules shall be those that are mandated by federal law governing the Iowa MCH program where the department has no option but to adopt such rules as specified and where federal funding for the MCH programs is contingent upon the adoption of the rules. Copies of the federal legislation adopted by reference are available from Chief, Family Services Bureau, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

641—76.3(135)
Rule coverage.

These rules cover agencies contracting with the department to pro-vide community-based MCH public health services and to receive funds from the department for that purpose. The contract agencies conduct essential public health services directed toward the maternal and child health populations consistent with the state's MCH services block grant state plan. The state plan is developed and administered collaboratively by the family services bureau of the department and CHSC.

641—76.4(135)
Definitions.

“Applicant” means a private nonprofit or public agency that seeks a contract with the department to provide MCH services.

“Care/service coordination” means a process of linking the service system to the recipient and organizing the various elements in order to achieve a successful outcome. The terms “care coordination” and “service coordination” may be used interchangeably.

“Children with Special Health Care Needs (CSHCN)” means children with chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by children generally.

“CHSC” means Child Health Specialty Clinics, a statewide program for children with special

health care needs authorized under Title V of the Social Security Act.

“Client” means an individual who receives MCH services through a contract agency.

“CMS” means the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration).

“Contract agency” means a private nonprofit or public agency that has a contract with the department to provide MCH services and receives funds from the department for that purpose.

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“*Core public health functions*” means the functions of community health assessment, policy development, and assurance.

1. Assessment: regular collection, analysis, interpretation, and communication of information

about health conditions, risks, and assets in a community. 2. Policy development: development, implementation, and evaluation of plans and policies, for public health in general and priority health needs in particular, in a manner that incorporates scientific information and community values and is in accordance with state public health policy.

3. Assurance: ensuring, by encouragement, regulation, or direct action, that programs and interventions that maintain and improve health are carried out.

“*Dental home*” means a usual source of dental care where dental care services are provided in a primary care setting where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. In addition, the dental care provider and parents partner to identify and access all the dental and nondental services needed to help children and their families achieve maximum oral health.

“*Department*” means the Iowa department of public health.

“*DHHS*” means the United States Department of Health and Human Services.

“*DIA*” means the Iowa department of inspections and appeals.

“*Direct health services*” means those services generally delivered one-on-one between a health

professional and a client in an office or clinic.

“*Director*” means the director of the Iowa department of public health.

“*Enabling services*” means services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include activities such as outreach, case management, health education, transportation, translation, home visiting, smoking cessation, nutrition, support services, and others.

“*EPSDT*” means the Early and Periodic Screening, Diagnosis, and Treatment program which provides for regular preventive health care services for children aged 0 to 21 as authorized by Title XIX of the Social Security Act.

“*Essential public health services*” means those activities carried out by public health entities and their contractors that fulfill the core public health functions in the promotion of maternal and child health.

“*Family*,” for the purpose of establishing eligibility, means a group of two or more persons related by birth, marriage or adoption or residing together and functioning as one socioeconomic unit. For the purpose of these rules, a pregnant woman is considered as two individuals when calculating the number of individuals in the family. If a pregnant woman is expecting multiple births, the family size is thereby increased by the number expected in the multiple birth.

“*Family planning*” means the promotion of reproductive and family health by the prevention of and planning for pregnancy, and reproductive health education.

“*Gap filling*” means direct health services supported by Title V staff or resources that are needed by children with special health care needs but are not otherwise accessible in the community.

“*hawk-i*” means healthy and well kids in Iowa and is the child health insurance program in Iowa as authorized in Title XXI of the Social Security Act.

“*HCFA*” means the DHHS, Health Care Finance Administration.

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“Health education” means services provided by a health professional to include instruction about normal anatomy and physiology, growth and development, safety and injury prevention, signs or symptoms indicating need for medical care, and other anticipatory guidance topics. *“Health professional”* means an individual who possesses specialized knowledge in a health or social science field or is licensed to provide health care. *“Health services”* means services provided through MCH contract agencies.

“Informing” means the act of advising families of the services available through the EPSDT/Care for Kids program, explaining what to expect at screening, and providing information about health re-sources in the community.

“Infrastructure building” means activities directed at improving and maintaining the health status of all clients by providing support for the development and maintenance of comprehensive health services systems including development and maintenance of health services standards or guidelines, training, data, and planning systems.

“MCH services” means essential public health services provided by MCH contract agencies.

“Medicaid” means the Medicaid program authorized by Title XIX of the Social Security Act and funded through the Iowa department of human services from the DHHS.

“Medical home” means a usual source of health care where the physician/health care provider is available to coordinate preventive, primary and follow-up care at all times (24 hours per day, seven days per week) for the patient while maintaining the client’s health records. In addition, the physician/ health care provider and parents partner to identify and access the medical and nonmedical services needed to help children and their families achieve their maximum potential.

“Nutrition screening” means nutrition education appropriate to the needs of the client, and referral to a licensed dietitian if indicated.

“OMB” means the United States Department of the Treasury, Office of Management and Budget.

“Oral health counseling” means services to assess oral health status and to provide education appropriate to the needs of the client and referral to a dentist if indicated.

“Oral health education” means information provided by a health professional about dental disease, prevention, and oral hygiene and other anticipatory guidance.

“Parenting education” means educational services for parents or expectant parents provided by health professionals to include care of infants and children, normal development, discipline, and other topics as appropriate.

“Performance measures” means a narrative statement that describes a specific maternal and child health need or requirement that, when addressed, will lead to a specific health outcome within a community and generally within a specified time frame.

“Performance standards” means criteria or indicators of the quality of service provided or the capability of a contract agency to provide public health services in a cost-effective or efficient manner as identified in the quality assurance section (501) of the MCH Administrative Manual. Copies of the performance standards are available from the Chief, Family Services Bureau, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, or on the Iowa department of public health Web site (<http://www.idph.state.ia.us>).

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“*Pharmacist*” means a person currently licensed to practice pharmacy under Iowa Code chapter 155.

“*Physician*” means a person currently licensed to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy under Iowa Code chapters 148 and 150A. “*Population-based services*” means preventive interventions and personal health services, developed for and available to the entire MCH population of the state rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components.

“*Prenatal and postpartum care*” means those types of services as recognized by the American College of Obstetricians and Gynecologists.

“*Program income*” means gross income earned by the contract agency from activities in which part or all of the cost is either borne as a direct cost by the funds received from the department or counted as a direct cost toward meeting cost-sharing or matching requirements of the contract agency. “Program income” includes but is not limited to such income in the form of fees for services, third-party reimbursements, and proceeds from sales of tangible, personal or real property.

“*Psychosocial services*” means screening activities that include social assessment and assisting with a family’s additional needs for support and referral.

“*Title V*” means Title V of the Social Security Act and the federal requirements contained in the Omnibus Reconciliation Act of 1989 (Public Law 101-239) which address the Maternal and Child Health and Children with Special Health Care Needs programs.

“*Title X*” means the program authorized in the federal regulations found in 42 CFR Subpart A, Part 59, published in the Federal Register on June 3, 1980, and the Program Guidelines for Project Grants for Family Planning Services. “*Title XIX*” means the Medicaid program authorized in the Social Security Act and funded through the Iowa department of human services from the DHHS.

“*Title XXI*” means the child health insurance program authorized in the Social Security Act and implemented in Iowa as the HAWK-I program as administered by the Iowa department of human services.

“*Well-child health care*” means those types of services as recognized by the latest edition of the American Academy of Pediatrics, Guidelines for Health Supervision.

“*WIC*” means the Special Supplemental Nutrition Program for Women, Infants and Children, funded through the department from the United States Department of Agriculture.

641—76.5(135)
MCH services.
76.5(1)
Infrastructure
building
services.

The following public health services shall be provided by contract agencies:

- a. Community assessment activities to identify population-based health conditions, risks, and assets in the community.
- b. Analysis of health data to determine community population-based health status, health system utilization and community resources.
- c. Methodological support for data collection, analysis and dissemination.
- d. Community planning activities to promote family and community health initiatives based on scientific, economic, and political factors.
- e. Promotion of regulations, standards, and contracts that protect the public’s health and safety.

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- f. Monitoring and evaluating the effectiveness, accessibility and quality of personal health and population-based services in the community.
- g. Supporting innovative initiatives to gain new insights and solutions to family and community health-related needs.
- h. Development of state plan and annual report in conjunction with the family services bureau.
- i. Development of systems for transitioning adolescents with special health care needs to adult services.

76.5(2)

Population-based services.

- a. Immunization.
- b. Injury prevention.
- c. Outreach and health education.
- d. Counseling for families who have lost a child to sudden infant death syndrome.
- e. Childhood lead poisoning screening.
- f. Support screening and follow-up for sickle cell disease and other hemoglobin disorders.

76.5(3) Enabling services.

- a. Care/service coordination.
- b. Informing.
- c. Outreach to families and children who do not access a regular and continuous source of health care (medical and dental home).
- d. Coordination of local systems of care for improving access to health services.
- e. Access to translation services.
- f. Access to transportation.
- g. Parent-to-parent support for families who have children with special health care needs.
- h. Information and outreach to families applying for the Supplemental Security Income program (Title XVI).
- i. Rescinded IAB 2/6/02, effective 3/13/02.

76.5(4) Direct health services.

Direct health services may be provided to meet identified community needs. The following preventive direct health services may be supported by MCH program funds to the extent the comprehensive community assessment documents that the services are not otherwise available from health professionals within the community. Payment shall be based upon Title XIX rates to the extent that current Title XIX rate information is available to the department. Contract agencies may enter into agreements that reimburse less than the Title XIX rate. Agencies shall not reimburse a provider under sanction by CMS.

a. Child health.

- (1) Informing.
- (2) Care/service coordination.
- (3) Nutrition counseling.
- (4) Psychosocial services.
- (5) Parenting education.
- (6) Health education.
- (7) Well-child health services include routine, ambulatory well-child care.
- (8) Assistance in establishing a medical and dental home or usual source of care.
- (9) Referral.

Continued on next page

- b. Prenatal and postpartum services.*
- (1) Care/service coordination.
 - (2) Risk assessment.
 - (3) Psychosocial screening assessment and counseling.
 - (4) Nutrition assessment and counseling.
 - (5) Health education.
 - (6) Routine, ambulatory prenatal medical care, postpartum exams, and family planning services.
- c. Dental health—maternal and child.*
- (1) Oral screening.
 - (2) Dental treatment services through referral.
 - (3) Oral health education.
 - (4) Fluoride varnish application.
- d. Children with special health care needs.* Community-based pediatric subspecialty clinic services that are “gap filling.”
- 641—76.6(135) Client eligibility criteria.**
- 76.6(1) Age.**
- a.* Prenatal program—no age restrictions.
 - b.* Child health care services—birth through 21 years of age.
 - c.* CHSC—birth through 21 years of age.
- 76.6(2) Income.**
- a.* Income guidelines will be the same as those established for the state’s Title XXI program.
Guidelines are published annually by DHHS. Department income guidelines will be adjusted following any change in DHHS guidelines.
 - b.* Income information will be provided by the individual, who will attest in writing to the accuracy of the information contained in the application.
 - c.* Proof of Title XIX or Title XXI (HAWK-I) eligibility will automatically serve in lieu of an application.
 - d.* All income of family members as defined by DHHS poverty guidelines will be used in calculating the individual’s gross income for purposes of determining initial and continued eligibility.
 - e.* Income will be calculated as follows:
 - (1) Annual income will be estimated based on the individual’s income for the past three months unless the individual’s income will be changing or has changed, or
 - (2) In the case of self-employed families the past year’s income tax return (adjusted gross income) will be used in estimating annual income unless a change has occurred.
 - (3) Terminated income will not be considered.
 - f.* Individuals will be screened for eligibility for Title XIX and Title XXI (HAWK-I). If an individual’s income falls within the eligibility guidelines for Title XIX and Title XXI (HAWK-I), the individual should be referred to the Iowa department of human services or other enrollment source to apply for coverage. Pregnant women shall be considered for Title XIX presumptive eligibility. Children shall be considered for Title XIX eligibility to the extent these activities are approved by the Iowa department of human services.

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g. An individual whose income is above the poverty level established by Title XXI and below 300 percent of the federal poverty guidelines will qualify for services on a sliding fee scale, as determined by the local agency's cost for the service. The department provides annual guidelines. An individual whose income is at or above 300 percent will qualify for services at full fee.

h. Eligibility determinations must be performed at least once annually. Should the individual's circumstances change in a manner which affects third-party coverage or Title XIX/Title XXI eligibility, eligibility determinations shall be completed more frequently.

76.6(3)

Residency.

Individuals must be currently residing in Iowa.

76.6(4)

Pregnancy.

An individual applying for the prenatal program shall have verification of pregnancy by an independent health provider, by the maternal health contract agency, or by a family planning (Title X) agency.

76.6(5) *Children with special health care needs.*

An individual applying for CHSC services shall be determined to have a special health care need as defined by the federal MCH bureau. Children aged 0 to 21 residing in Iowa with or at risk of having a special health care need are eligible for CHSC services. Care/service coordination or other nonclinic services are provided at no charge to the family. Clinic services are provided without charge to families with adjusted gross incomes below 185 percent of the federal poverty guideline. Families above this threshold are responsible for payment according to a sliding fee scale based on tax exemptions, adjusted gross income, and extenuating circumstances.

641—76.7(135)

Client application procedures for MCH services.

76.7(1)

A person or the parent or guardian of a minor desiring direct health services other than those provided to children with special health care needs shall apply to a contract agency using a Health Services Application, Form 470-2927, 470-2927(SP), or the alternate form authorized by the HAWK-I board.

76.7(2)

The contract agency shall verify the following information to apply for MCH services under this program:

a. The information requested on the application form under "Household Information."

b. Income information for all family members or proof of eligibility for Title XIX (Medicaid) or Title XXI (HAWK-I).

c. Information about health insurance coverage.

d. The signature of the individual or responsible adult, dated and witnessed.

e. For pregnant women, denial of benefits under Title XIX (Medicaid) due to economic or categorical ineligibility.

76.7(3)

If an individual has completed a Health Services Application, Form 470-2927, within the last year and the form accurately documents the current financial and family status, the MCH contract agency shall accept a copy of that application and determine eligibility without requiring completion of any other application form.

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- 76.7(4)** If an individual indicates on the Health Services Application, Form 470-2927, that the individual also wishes to apply for WIC or Medicaid or HAWK-I, the contract agency shall forward the appropriate copy to the indicated agency within two working days.
- 76.7(5)** The contract agency shall determine the eligibility of the family and the percent of the cost of care that is the family's responsibility. The individual shall be informed in writing of eligibility status prior to incurring costs for care.
- 76.7(6)** Once an individual has been determined to be eligible, the individual shall report any changes in income, family composition, or residency to the contract agency within 30 days from the date the change occurred.
- 76.7(7)** A family seeking direct health care or care/service coordination services for a child with special health care needs shall follow CHSC policies and procedures. Insurance status and eligibility for the sliding fee scale are determined during the patient registration process.
- 641—76.8(135)**
Right to appeal—client.
- 76.8(1) *Right of appeal.*** Individuals applying for MCH services and clients receiving MCH services shall have the right to appeal whenever a decision or action of the department or contract agency results in the denial of participation, suspension, or termination from the approved MCH program. Notification of the denial of participation, suspension or termination shall be made in writing and shall state the basis for the action. All hearings shall be conducted in accordance with these rules.
- 76.8(2) *Notification of appeal rights and right to hearing.*** Individuals applying for MCH services shall be notified of the right to appeal and the procedures for requesting a hearing at the time of application for MCH services. Information about the appeal and hearing process shall be provided in writing and shall be immediately available at maternal and child health centers. A health professional shall be available to explain the method by which an appeal or hearing is requested and the manner in which the appeal and hearing will be conducted.
- 76.8(3) *Request for hearing.*** A request for a hearing is a written expression by an individual or the individual's parent, guardian, or other representative that an opportunity to present the individual's case is desired. The request shall be filed with the contract agency within 60 days from the date the individual receives notice of the decision or action which is the subject of appeal.
- 76.8(4) *Receipt of benefits during appeal.*** Individual applicants, who are denied program benefits due to a finding of ineligibility, shall not receive benefits during the administrative appeal period. Clients who are involuntarily suspended or terminated from the MCH program shall continue to receive program benefits during the administrative appeal period.
- 76.8(5) *Hearing officer.*** The hearing officer shall be impartial, shall not have been directly involved in the initial determination of the action being contested, and shall not have a personal stake in the decision. Hearing officers may be contract agency directors, health professionals, community leaders, or any impartial citizen. If prior to the hearing, the appealing party objects to a contract agency director serving as the hearing officer in a case involving the director's own agency, another hearing officer shall be selected and, if necessary, the hearing shall be rescheduled as expeditiously as possible. Contract agencies may seek the assistance of the Chief, Family Services Bureau, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, in the appointment of a hearing officer.

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- 76.8(6) Notice of hearing.** The hearing officer shall schedule the time, place and date of the hearing as expeditiously as possible. Parties shall receive notice of the hearing at least ten days in advance of the scheduled hearing. The hearing shall be accessible to the party requesting the hearing. The hearing shall be scheduled within three weeks from the date the contract agency received the request for a hearing or as soon as possible thereafter, unless a later date is agreed upon by the parties.
- 76.8(7) Conduct of hearing.** The party requesting the hearing or the party's representative shall have the opportunity to:
- a. Examine, prior to and during the hearing, the documents and records presented to support the decision under appeal;
 - b. Be represented by an attorney or other person at the party's own expense;
 - c. Bring witnesses;
 - d. Question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses;
 - e. Submit evidence to establish all pertinent facts and circumstances in the case; and
 - f. Advance arguments without undue interference.
- 76.8(8) Decision.** Decisions of the hearing officer shall be in writing and shall be based on evidence presented at the hearing. The decision shall summarize the facts of the case, specify the reasons for the decision, and identify the supporting evidence and pertinent regulations or policy. The decision shall be issued within 90 days of the receipt of the request for the hearing, unless a longer period is agreed upon by the parties.
- 76.8(9) Appeal of decision to the department.** A party receiving an unfavorable decision may file an appeal with the department. Such appeals must be filed within 15 days of the mailing date of the hearing decision. Appeals shall be sent to the Division Director, Family and Community Health, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.
- 76.8(10) Contested case.** Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the DIA pursuant to the rules adopted by the DIA regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information, which may be provided by the aggrieved party, shall also be provided to the DIA.
- 76.8(11) Hearing.** Parties shall receive notice of the hearing in advance. The administrative law judge shall schedule the time, place and date of the hearing so that the hearing is held as expeditiously as possible. The hearing shall be conducted according to the procedural rules of the DIA found in 481—Chapter 10, Iowa Administrative Code.
- 76.8(12) Decision of administrative law judge.** The administrative law judge's decision shall be issued within 60 days from the date of request for hearing. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final decision without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 76.8(13).
- 76.8(13) Appeal to the director.** Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

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- 76.8(14)** *Record of hearing.* Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:
- a. All pleadings, motions and rules.
 - b. All evidence received or considered and all other submissions by recording or transcript.
 - c. A statement of all matters officially noticed.
 - d. All questions and offers of proof, objections and rulings thereon.
 - e. All proposed findings and exceptions.
 - f. The proposed decision and order of the administrative law judge.
- 76.8(15)** *Decision of director.* An appeal to the director shall be based on the record of the hearing before the administrative law judge. The decision and order of the director becomes the department's final decision upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.
- 76.8(16)** *Exhausting administrative remedies.* It is not necessary to file an application for the re-hearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final decision of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.
- 76.8(17)** *Petition for judicial review.* Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the director by certified mail, return receipt requested, or by personal service. The address is Director, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.
- 76.8(18)** *Benefits after decision.* If a final decision is in favor of the person requesting a hearing and benefits were denied or discontinued, benefits shall begin immediately and continue pending further review should an appeal to district court be filed. If a final decision is in favor of the contract agency, benefits shall be terminated, if still being received, as soon as administratively possible after the issuance of the decision. Benefits denied during an administrative appeal period may not be awarded retroactively following a final decision in favor of a person applying for MCH services.
- 641—76.9(135)** **Grant application procedures for community-based contract agencies.** Private nonprofit or public agencies seeking to provide community-based Title V-MCH public health services shall file a letter of intent to make application to the department no later than April 1 of the competitive year. Applications shall be to administer MCH services for a specified project period, as defined in the request for proposal, with an annual continuation application. The contract period shall be from October 1 to September 30 annually. All materials submitted as part of the grant application are considered public records in accordance with Iowa Code chapter 22, after a notice of award is made by the department. Notification of the availability of funds and grant application procedures will be provided in accordance with the department rules found in 641—Chapter 176. Contract agencies are selected on the basis of the grant applications submitted to the department. The department will consider only applications from private nonprofit or public agencies. In the case of competing applications, the contract will be awarded to the applicant that scores the highest number of points in the review.

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- 641—**
76.10(135)
Funding levels for community-based contract agencies.
641—
76.11(135)
Contract agency performance.
76.11(1)
Performance standards.
- The amount of funds available to each contract agency on an annual basis shall be determined by the department using a methodology based upon dollars available, number of clients enrolled, and selected needs criteria. A contract agency will receive four dollars of the available funds from the department for each one dollar of matching funds up to but not to exceed the total available funds for that contract agency.
- Contract agencies are required to provide services in accordance with these rules.
- 76.11(2)**
Contract agency review.
- The department shall establish performance standards that contract agencies shall meet in the provision of public health services. The performance standards for community-based agencies are published in the quality assurance section (501) of the MCH Administrative Manual. Copies of the performance standards are available from the Chief, Family Services Bureau, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, or on the Iowa department of public health Web site (www.idph.state.ia.us). Contract agencies that do not meet the performance standards shall not be eligible for continued funding as an MCH contract agency unless the contract agency has secured an exception.
- The department shall review contract agency operations through the use of reports and documents submitted, state-generated data reports, chart audits, on-site and clinic visits for direct care services as applicable for evaluation and technical assistance.
- 76.11(3)**
Exception.
- A contract agency that does not meet a performance standard or fails to meet an action plan as approved by the department may be granted an exception for up to one year in order to improve performance. Such an exception must be requested in writing. If granted, the approval for the exception will include the conditions necessary for the successful completion of the standard, a time frame, and additional reporting requirements. The procedures for applying for and approving of an exception are outlined in the “Performance Standards, Maternal and Child Health Contractors, Family Services Bureau.”
- 641—**
76.12(135)
Reporting.
641—
76.13(135)
Fiscal management.
76.13(1) *Last pay.*
- Completion of grant applications, budgets, expenditure reports, annual progress reports, and data forms shall be performed by contract agencies in compliance with the contract with the department.
- All contract agencies are required to meet fiscal management policies.
- 76.13(2)**
Program income.
- MCH grant funds are considered last pay. Title XIX and other third-party payers are to be billed first if other resources cover the service.
- Program income shall be used for allowable costs of the MCH program. Program income shall be used before using the funds received from the department. Excess program income may be retained to build a three-month operating capital. Program income shall be used during the current fiscal year or the following fiscal year. Five percent of unobligated program income may be used by the contract agency for special purposes or projects provided such use furthers the mission of the MCH program and does not violate state or federal rules governing the program.

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- 76.13(3)**
Advances. A contract agency may request an advance of up to one-sixth of its contract at the beginning of a contract year. The amount of any advance will be deducted prior to the end of the fiscal year.
- 76.13(4)** *Local share.* Community-based contract agencies are required to match the MCH funds received from the department at a minimum rate of one dollar of local match for every four dollars received from the department. Sources that may be used for match are reimbursement for service from third parties such as insurance and Title XIX, client fees, local funds from nonfederal sources, or in-kind contributions. In-kind contributions must be documented in accordance with generally accepted accounting principles.
- 76.13(5)**
Subcontracts. Contract agencies may subcontract a portion of the project activity to another entity provided such subcontract is approved by the department. Subcontract agencies must follow the same rules, procedures, and policies as required of the contract agency by these rules and contract with the department. The contract agency is responsible for ensuring the compliance of the subcontract. Subcontract agencies may not subcontract these project activities with other entities.
- 641—**
76.14(135)
Audits. Every two years, each contract agency shall undergo financial audit of the MCH program. The audit shall be conducted in compliance with OMB Circular A-133 Audits of States, Local Governments, and Non-Profit Organizations. Each audit shall cover all unaudited periods through the end of the previous grant year. The department's audit guide should be followed to ensure an audit which meets federal and state requirements.
- 641—**
76.15(135)
Diagnosis and therapeutic services for children. Rescinded IAB 2/6/02, effective 3/13/02.
- 641—**
76.16(135)
Denial, suspension, revocation or reduction of contracts with contract agencies. The department may deny, suspend, revoke or reduce contracts with contract agencies in accord with applicable federal regulations or contractual relationships. Notice of such action shall be in writing.
- 641—**
76.17(135)
Right to appeal—contract agency. Community-based contract agencies may appeal the denial of a contract or the suspension, revocation or reduction of an existing contract.
- 76.17(1)** *Appeal.* The appeal shall be made in writing to the department within ten days of receipt of notification of the adverse action. Notice is to be addressed to the Division Director, Family and Community Health Division, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

Continued on next page

- 76.17(2)**
Contested case. Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the DIA pursuant to the rules adopted by the DIA regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information, which may be provided by the aggrieved party, shall also be provided to the DIA.
- 76.17(3)**
Hearing. Parties shall receive notice of the hearing in advance. The administrative law judge shall schedule the time, place and date of the hearing so that the hearing is held as expeditiously as possible. The hearing shall be conducted according to the procedural rules of the DIA found in 481—Chapter 10.
- 76.17(4)**
Decision of administrative law judge. The administrative law judge’s decision shall be issued within 60 days from the date of request for hearing. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department’s final decision without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 76.17(5).
- 76.17(5)** *Appeal to the director.* Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge’s proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.
- 76.17(6)** *Record of hearing.* Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:
- a. All pleadings, motions and rules;
 - b. All evidence received or considered and all other submissions by recording or transcript;
 - c. A statement of all matters officially noticed;
 - d. All questions and offers of proof, objections and rulings thereon;
 - e. All proposed findings and exceptions; and
 - f. The proposed decision and order of the administrative law judge.
- 76.17(7)**
Decision of director. An appeal to the director shall be based on the record made at the hearing. The decision and order of the director becomes the department’s final decision upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.
- 76.17(8)**
Exhausting administrative remedies It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final decision of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A. Petition for judicial review must be filed within 30 days after decision becomes final.

Continued on next page

These rules are intended to implement Iowa Code section 135.11.

[Filed 9/30/88, Notice 8/10/88—published 10/19/88, effective 11/23/88]

[Filed emergency 7/21/89—published 8/9/89, effective 7/21/89]

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[Filed 3/13/92, Notice 2/5/92—published 4/1/92, effective 5/6/92]

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[Filed 1/10/02, Notice 11/28/01—published 2/6/02, effective 3/13/02]

Appendix A3: Glossary

This glossary provides definitions of words, acronyms, and phrases that appear in the manual. Additional public health terms can be found on the definitions page at the IDPH Web site: <http://www.idph.state.ia.us/definitions.asp>. The IDPH definitions page contains an alphabetical listing of terms used by the Iowa Department of Public Health including government pseudonyms and acronyms.

Access to Care	An individual and/or family's ability to secure health care services and products. The terms availability, accessibility, accommodation, affordability, and acceptability further delineate access. <i>Availability</i> reflects the supply of services available in the area. <i>Accessibility</i> concerns location and ease of transportation to the service. <i>Accommodation</i> includes convenience of hours the service is available, ease of obtaining appointments, and presence or absence of bureaucratic barriers. <i>Affordability</i> concerns the cost to the client, and <i>acceptability</i> is how the client views the provider and the provider views the client.
Assess	Regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiological and other studies of health problems.
Assets	Significant community resources and developments resulting from local community agencies and individuals who are committed to investing themselves and their resources into enhancing the health of women, children, and families.
Assurance	Services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (private or public sector), by requiring such action through regulation, or by providing services directly.
At-risk population	People with factors that make them more vulnerable to negative health care outcomes.
Board of Health (BOH)	A county, city, or district board of health as defined in the Code of Iowa, Section 137.2. It is the governing authority of a local health department.
Bureau of Family Health (BFH)	The organizational entity responsible for MCH programs within the Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health.
Care Coordination	The process of linking the service system to the recipient and/or family, and coordination of the various elements in order to achieve a successful outcome.

CAReS	The Child and Adolescent Reporting System. CAReS is the data system used to monitor needs and record provision of services for the child health program. CAReS serves as the child's official clinical record
CCRR	Child Care Resource and Referral
Child Health (CH) program	Child health services provided or assured under the Iowa Administrative Code 641 IAC 76.
Child Population	Children from birth through 21 years of age; for data purposes IDPH uses the U.S. Census data.
CHNA & HIP	The Community Health Needs Assessment and Health Improvement Plan.
CLPPP	The Childhood Lead Poisoning Prevention Project.
Client	An individual who receives MCH services through a contractor.
CMS	The Centers for Medicare and Medicaid Services of the U. S. Department of Health and Human Services.
Collaboration	The process of individuals or organizations jointly sharing resources and responsibilities to plan, implement and evaluate programs to achieve common goals.
Community	The boundaries within which a problem can be defined, dealt with, and solved; (e.g., political boundaries, county boundaries, catchment areas, neighborhoods, school district boundaries, or cultural boundaries of a group of people.) This may be the political lines of county boundaries, service areas in which a contractor provides services, or it may be defined by the presence of significant numbers of a particular cultural group. (Definition from the National Commission on Community Health Services, 1960.)
Community-Based	Coming from within the community, or ideas, services, or programs that are shaped by the unique characteristics, culture, and resources present in a community.
Community Empowerment Area	A geographic area as designated in accordance with Iowa Administrative Code 349 IAC 1.
Community Health Needs Assessment	The portion of a community needs assessment that relates to health related issues, problems, challenges, and desired outcomes.

Contract	A mutually signed agreement by individuals or organizations to share resources and/or responsibilities to jointly plan, implement or evaluate programs to achieve common goals.
Contract Agency	An organization holding a contract with the Iowa Department of Public Health, Bureau of Family Health for the programs of Child Health (including EPSDT, dental health and <i>hawk-i</i>), Maternal Health, and/ or Family Planning.
Contractor	The organizational entity holding the contract for a program. The contractor retains full responsibility for the conduct and operations of all subcontracted entities.
Cooperation	Individuals or organizations associating to accomplish a common goal.
Cooperative Agreement	A mutually signed agreement outlining a relationship between two or more entities to carry out or deliver a product or service.
Coordination	Individuals or organizations working together to accomplish a common goal.
Core Public Health Functions	The functions of community health assessment, policy development, and assurance.
Culturally Competent	Organizing systems to be culturally sensitive to diverse groups so they can be better served through recognition and inclusion of their differing values, beliefs and practices at the program level. This must first be accepted and incorporated at the policymaking and administration levels.
Dental Home	An approach to providing dental care services in a primary care setting where care is accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. Dentists and parents can act as partners to identify and access all the dental and non-dental services needed to help children and their families achieve maximum oral health.
Dental Treatment	Dental services provided for treatment of any existing disorder, lesion, injury, deformity, or defect of the oral cavity, teeth, gums or maxillary bones of the human being or to give prophylactic treatment to any of these organs.
Department	The Iowa Department of Public Health.
DHHS	The United States Department of Health and Human Services.
DHS	The Iowa Department of Human Services.
Director	The director of the Iowa Department of Public Health.
DIA	The Iowa Department of Inspections and Appeals.

Direct Health Services	Those services generally delivered one-on-one between a health professional and a client, usually in an office, clinic or home. For the purposes of the Child Health program, direct care means a complete well-child screen or any component of the well-child screen. For purposes of the Maternal Health program, direct care refers to the medical prenatal care for pregnant women.
Early ACCESS	Iowa's Early Intervention Program(Part C IDEA). Early ACCESS is a partnership between families with young children, birth to age three, and providers from the Departments of Education, Public Health, Human Services, and the Child Health Specialty Clinics. Families and staff work together to find, organize, and provide needed services and resources that will help the family help their infant or toddler grow and develop. Children are eligible if they are under age three and have a condition that may affect their growth and development, or have delays in their ability to play, think, talk and move.
Enabling Services	Services needed by some individuals in order for them to access and benefit from basic available health care. This may include such activities as outreach, care coordination, health education, transportation, language translation, home visits, and other support services.
EPSDT	The Early Periodic Screening, Diagnosis, and Treatment program under Medicaid.
Essential Public Health Services	The activities carried out by various public health entities and their contractors that fulfill the core public health functions related to promoting maternal and child health.
Evaluation	The systematic measurement of results by comparing collected data with pre-established standards or controls.
Family	A group of two or more persons related by birth, marriage, or adoption who live together and function as one economic unit. A pregnant woman is considered as two individuals when calculating the number of individuals in a family. If a pregnant woman is expecting multiple births, the family size should be increased by the number expected in the multiple birth.
Family-Centered	Establishing a relationship in which family members and professionals work together to ensure provision of the best available services for a family or family member. It recognizes and respects the knowledge, skills and experience that families and professionals bring to the relationship and acknowledges that the development of trust is an integral part of a collaborative relationship. It facilitates open communication so that families and professionals feel free to express themselves and creates an atmosphere in which the cultural traditions, values, and diversities of families are acknowledged and honored. It also recognizes that negotiation is essential in

a collaborative relationship and brings to the relationship the mutual commitment of families, professionals, and communities in response to the concerns, priorities, and resources of the involved families.

FFY	The Federal Fiscal Year that begins on October 1 and ends on September 30.
Family Planning (FP)	Services provided under Iowa Administrative Code 641 IAC 74.
FTE	A full-time equivalent position of 2,080 hours per year.
Goals	The guiding dreams, ideals, or visions that the program strives for in the future.
<i>hawk-i</i>	Healthy and Well Kids in Iowa. <i>hawk-i</i> is the state's child health insurance program as authorized in Title XXI of the Social Security Act.
HCCI	Healthy Child Care Iowa
Health Disparities	Higher levels of disease and disability found in minority, racial, and ethnic populations.
Health Education	Services provided by a health professional that include instruction about normal anatomy and physiology, growth and development, safety and injury prevention, signs or symptoms indicating need for physician care, and other anticipatory guidance topics.
Health Professional	An individual who is licensed to provide health care or social services within a defined scope of practice.
Health Hazard	A physical, social, or environmental factor that potentially poses a risk to women, infants, children, or youth.
HIV	human immunodeficiency virus
HMO	Health Maintenance Organization
HOPES	The Healthy Opportunities for Parents to Experience Success program.
HRSA	The federal Health Resources and Services Administration
IAC	The Iowa Administrative Code
ICN	The Iowa Communications Network, the state's fiber optic network.
IDPH	The Iowa Department of Public Health.

IFSP	An Individualized Family Service Plan.
In writing	Materials required to be sent to the Bureau of Family Health in writing may be submitted by email or letter.
Indicator	A variable that is measurable based on data and typically used to show progress toward a goal.
Informing	The act of advising families of the services available through the EPSDT/ <i>Care for Kids</i> program, explaining what to expect at the screening and providing information about health resources in the community. The components of the informing process include an initial inform, inform follow-ups, inform completion and re-inform.
Infrastructure Building	Activities directed at improving and maintaining health status by providing support for the development and maintenance of comprehensive health services systems including development and maintenance of health service standards or guidelines, training, data, and planning systems.
Local Funds	Any funds available within or from a community source; (e.g. funds from client fees, from fund-raising events, or private donations).
Maternal Health Center	Provider status under Medicaid for maternal health contractors.
MCH	The Maternal and Child Health programs.
MCHB	The Maternal and Child Health Bureau of the U.S. Department of Health and Human Services.
Medicaid	The public insurance program authorized under Title XIX of the Social Security Act.
Medical Home	An approach to providing health care services in a primary care setting where care is accessible, family centered, continuous, comprehensive, coordinated, compassionate, and culturally competent. Physicians and their staff can partner with parents to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential.
Maternal Health (MH) Program	Services for pregnant and postpartum women provided or assured under the <i>Iowa Administrative Code</i> 641, chapter 76.
Minority Populations	Those individuals who are members of the following populations: African-American or Black, Native American Indian, Eskimo or Aleut, Asian or Pacific Islander, and Hispanic or Latino. It also includes immigrant populations such as Sudanese, Bosnian, and Serbian.

Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU)	A mutually signed agreement by individuals or organizations to share resources and/or responsibilities to jointly plan, implement, or evaluate programs to achieve common goals.
Monitoring	Ongoing assessment and evaluation of an intervention that provides continuous feedback on performance.
Needs Assessment	The process of identifying and measuring the lack or insufficiency or the easy availability of something required or desired within a community, group of people, an individual family or person.
Networking	Individuals or organizations sharing information, ideas, resources, or services to accomplish individual or group goals.
NPM	National Performance Measure
OB Indigent Program	A funding assistance for pregnant women who have been denied Medicaid and are below 300% of the federal poverty level. The OB Indigent program will pay for prenatal, intrapartum, postpartum, and newborn hospital care for pregnant women in eligible counties.
Objective	Measurable commitments to action that clearly specify the amount and results the program promises to accomplish by a deadline.
OM	Outcome Measure.
OMB	The United States Department of Treasury, Office of Management and Budget.
Outreach	Activities to identify eligible persons for MCH, and FP program services and to familiarize them with these available services, and assist them in accessing information and/or services. Outreach activities may also be targeted to providers as a: of increasing provider participation in public health-related activities.
Partner	An individual or organization working with others to accomplish a common goal with a shared sense of purpose and sharing responsibility for the outcome.
Partnership	Individuals or organizations working together in a side-by-side effort to accomplish a common goal with a shared sense of purpose and a shared responsibility for the outcome.

Performance Standards	Criteria or indicators of the quality of service provided or the capability of a contractor to provide services in a cost-effective or efficient manner.
Personnel	People employed directly by the contractor or who have received a subcontract to provide direct health care services.
Population-Based Services	Preventive interventions and personal health services, developed for, and available to, the entire MCH population in the state rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components.
Prenatal and postpartum care	Types of services as recognized by the American College of Obstetricians and Gynecologists, Standard for Obstetrics Gynecologic Services.
Progress Report	The report due by the date specified in the contract each year in which contractors report the activities completed during the previous grant year to comply with MCH performance standards and individual contractor goals and objectives.
Project Director	The person who has been delegated authority to administer the project for the contractor as described in the Special Conditions of the contract.
Policy Development	The development of comprehensive public health policies by promoting use of scientific knowledge in decision-making about public health and by leading in developing public health policy.
Public funds	Funds that are collected through local, state, or federal taxation process.
Quality Assurance (QA)	Problem-solving approaches used to measure and monitor health care to ensure that it is effective and efficient.
RFA	The request for applications in the subsequent project period after a RFP.
RFI	A request for information used to provide IDPH with information to complete the RFP and RFA process.
RFP	The request for proposals used in a competitive bidding process.
Screening Center	Provider status under Medicaid for Child Health contractors.
Social Services Block Grant (SSBG)	The legislation established by the federal government in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). The SSBG replaced the previous federal social services program known as Title XX, and gave the states

substantial discretion in the use of block grant funds. The SSBG funds must be spent according to requirements in the Code of Federal Regulations, Title 45, Part 96 as amended. The Iowa regulations which apply to SSBG eligibility for services and their delivery are found in the Iowa Administrative Code 441 IAC 130 and 441 IAC 153. In addition, the Code of Iowa covers social services in chapters 171, 217, and 234.

Special Conditions	Unique conditions applying to the contract.
SPM	State Performance Measure.
State	State of Iowa
Subcontract	A mutually signed agreement between an organization with a contract to carry out or deliver a service or product and another organization that will assist the contractor in meeting the goals and objectives of the contract.
Subcontractor	Any organization holding a viable subcontract to provide services.
Target Population	The people identified as needing, requiring, or desiring a particular service.
Title V	The federal requirements contained in the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), which deals with the Maternal and Child Health program.
Title X	The federal categorical grant, which provides funding for family planning services (45, 108, June 3, 1980, Federal Register). The grant is administered by United States Department of Health and Human Services, Public Health Service, Office of Population Affairs.
Title XIX	The Medicaid program of the United States Department of Health and Human Services and the state matching funds program available through the Iowa Department of Human Services.
Title XX	Refers to the Social Services Block Grant (SSBG).
Title XXI	The Child Health Insurance Program (CHIP) authorized in the Social Security Act and implemented in Iowa as the <i>hawk-i</i> program as administered by the Iowa Department of Human Services.
WIC	The Special Supplemental Nutrition Program for Women, Infants, and Children under the Iowa Administrative Code 641 IAC 73.
WHIS	The Women's Health Information System, a local and state-level electronic record system of maternal and women clients of Title V contracted Maternal Health agencies.

Appendix A5: General Accounting Expenditure Form

Attach supporting documentation to the back of this form		STATE OF IOWA			GAX		
BUDGET FY	General Accounting Expenditure				DOCUMENT NUMBER		
DATE		ACCTG PERIOD (mm/yy)					
VENDOR CODE			AGENCY NAME				
VENDOR NAME AND ADDRESS			BILL TO ADDRESS (ORDERING AGENCY)		SHIP TO ADDRESS		
TERMS	FOB	ORDER APPROVED BY			GOODS RECEIVED/SERVICES PERFORMED INITIALS		
		DATE					
QUANTITY	VENDOR'S INVOICE DATE		VENDOR'S INVOICE NUMBER				
ORDERED	RECEIVED	UNIT OF MEASURE	DESCRIPTION			UNIT PRICE	TOTAL PRICE

DOCUMENT TOTAL

CLAIMANT'S CERTIFICATION				AGENCY CERTIFICATION			
I CERTIFY THAT THE ITEMS FOR WHICH PAYMENT IS CLAIMED WERE FURNISHED FOR STATE BUSINESS UNDER THE AUTHORITY OF THE LAW AND THAT THE CHARGES ARE REASONABLE, PROPER, AND CORRECT, AND NO PART OF THIS CLAIM HAS BEEN PAID.				I CERTIFY THAT THE ABOVE EXPENSES WERE INCURRED AND THE AMOUNTS ARE CORRECT AND SHOULD BE PAID FROM THE FUNDS APPROPRIATED BY:			
DATE		TITLE		CODE OR CHAPTER SECTION(S)			
CLAIMANT'S SIGNATURE				AUTHORIZED SIGNATURE			

THE FOLLOWING FIELDS ARE FOR STATE ACCOUNTING USE ONLY

DOC TYPE (PO or PV)	DOC NUMBER	DOC DATE	ACCTG PRD	BUDGET FY	ACTION NEW/MOD	PO SHIP INSTR	PV TYPE	INT IND	INT SELLER FUND	INT SELLER AGCY
GAX					E		1			
VENDOR CODE	ADDR OVERRIDE	F/A INDICATOR	EFT IND	TEXT-po's only (Y/N)	TEXT (po's only)					
REF DOC TYPE	REF DOC NUMBER	REF DOC LINE	COM LN	VEND INVOICE #	COMMODITY CODE	GS CONTRACT				

LINE	FUND	AGCY	ORG	SUB ORG	ACTV	FUNC	OBJT	SUB OBJT	JOB NUMBER	REP CAT	QUANTITY / UNITS	I/D	DESCRIPTION	AMOUNT	I/D	P/F
01		588										I				
02												I				
03												I				
04												I				
05												I				
06												I				
07												I				

07-350 IFAS PO/PV1 (3/99)

DOCUMENT TOTAL

GAX	WARRANT #	AUDITED BY		PAID DATE
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 **Appendix A6: Equipment Inventory Form**

EQUIPMENT INVENTORY FORM

Agency Name: _____

Date: _____

Inventory #	Description	Cost	Date	Serial #	Source of Funding
				Invoice #	
		\$			
		\$			
		\$			
		\$			
		\$			
		\$			

Appendix A7: Business Associate Agreement between IDPH and DHS

Business Associate Agreement

THIS ADDENDUM supplements and is made a part of the Iowa Department of Human Services ("Department") Contract (hereinafter, the "Underlying Agreement") between the Department and Iowa Department of Public Health ("the Business Associate"). This Addendum, when accepted by the Department, establishes the terms of the relationship between the Department and the Business Associate.

Whereas, the Department and the Business Associate are parties to the Underlying Agreement pursuant to which the Business Associate provides or performs certain services on behalf of or for the Department. The Department discloses to the Business Associate certain Protected Health Information ("PHI,")(as defined in 45 C.F. R. § 164.501), related to the services performed by the Business Associate for the relationship and, in connection with the provision of those services. This PHI is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

Whereas, the Department is a "Covered Entity" as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule");

Whereas, Iowa Department of Public Health, provides or performs certain services on behalf of or for the Department which require the disclosure of PHI from the Department, and is, therefore a "Business Associate" as that term is defined in the Privacy Rule;

Whereas, pursuant to the Privacy Rule and the Security Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

Whereas, the purpose of this Addendum is to comply with the requirements of the Privacy Rule and the Security Rule, including, but not limited to, the Business Associate's contract requirements at 45 C.F.R. §164.504(e) and 45 C.F.R. §164.314.

NOW, THEREFORE in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set forth in the Privacy Rule and the Security Rule.
2. **Scope of Use and Disclosure by Business Associate of Protected Health Information.**
 - a. The Business Associate shall be permitted to use and disclose PHI that is disclosed to it by the Department as necessary to perform its obligations under the Underlying Agreement.
 - b. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by

this Addendum or required by law, the Business Associate may:

- (1) Use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of DHS;
- (2) Disclose the PHI in its possession to a third party for the purpose of proper management and administration or to fulfill any legal responsibilities of DHS; provided, however, that the disclosures are required by law or Business Associate has received from the third party written assurances that:
 - (i) The information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and
 - (ii) The third party will notify the Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached; and
 - (iii) Disclose or use any PHI created or received by DHS under this Addendum, for other purposes, so long as it has been de-identified and the de-identification conforms to the requirements of the Privacy Rule.

3. Obligations of Business Associate. In connection with its use and disclosure of PHI, the Business Associate agrees that it will:

- a. Use or further disclose PHI only as permitted or required by this Addendum or as required by law.
- b. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum;
- c. To the extent practicable, mitigate any harmful effect that is known to the Business Associate of a use or disclosure of PHI in violation of this Addendum.
- d. Promptly report to the Department any use or disclosure of PHI not provided for by this Addendum of which the Business Associate becomes aware.
- e. Require contractors or agents to whom the Business Associate provides PHI to agree to the same restrictions and conditions that apply to the Business Associate pursuant to this Addendum.
- f. Make available to the Secretary of Health and Human Services the Business Associate's internal practices, books and records relating to the use and disclosure of PHI for purposes of determining the Business Associate's compliance with the Privacy Rule, subject to any applicable legal privileges.
- g. Obtain consents, authorizations and other permissions from all individuals necessary or required by laws applicable to the Business Associate to fulfill its obligations under the Underlying Agreement and this Addendum.
- h. Promptly comply with any changes in, or revocation of, permission by an Individual for the Business Associate or the Department to use or disclose PHI, after receiving written notice by the Department.

- i. Promptly comply with any restrictions on the use and disclosure of PHI about Individuals that the Department has agreed to, after written notice by the Department.
- j. Within (15) days of receiving a request from the Department, make available the information necessary for the Department to make an accounting of disclosures of PHI about an individual.
- k. Within ten (10) days of receiving a written notice from the Department about a request from the Individual, make available PHI necessary for the response to individuals' requests for access to PHI about them in the Business Associate's possession which constitutes part of the Department's Designated Record Set.
- l. Within fifteen (15) days of receiving a written notice from the Department to amend or correct an Individual's PHI in accordance with the Privacy Rule, make the amendments or corrections to PHI in Business Associate's possession which constitutes part of the Department's Designated Record Set.
- m. Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of the electronic PHI that it creates, maintains, or transmits on behalf of the Department. This security requirement is effective April 20, 2005.
- n. Promptly report to the Department any security incident of which the Business Associate becomes aware. This security requirement is effective April 20, 2005.

4. Obligations of the Department. The Department agrees that it:

- a. Has included, and will include, in the Department's required Notice of Privacy Practices that the Business Associate may disclose PHI for health care operations purposes.
- b. Has obtained, and will obtain, from Individuals authorizations and other permissions necessary or required by laws applicable to the Department and the Business Associate to fulfill their obligations under the Underlying Agreement and this Addendum.
- c. Will promptly notify Business Associate in writing of any restrictions on the use and disclosure of PHI about Individuals that the Department has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Addendum.
- d. Will promptly notify the Business Associate in writing of any changes in, or revocation of, authorization by an Individual to use or disclose PHI, if such changes or revocation may affect the Business Associate's ability to perform its obligations under the Underlying Agreement or this Addendum.

5. Termination.

- a. Termination for Cause. The Department may terminate this Addendum for cause if the Department determines that the Business Associate, or any of its subcontractors, etc. has breached a material term of this Addendum. The Department will allow the Business Associate an opportunity to cure the breach. The Department shall provide written notice to the Business Associate requesting that the breach be remedied within the period of time specified in the notice. If the breach is not remedied by the date specified to the satisfaction of the Department, the Department may immediately terminate this Addendum and the Underlying Agreement.

b. **Automatic Termination.** This Addendum will automatically terminate upon the termination or expiration of the Underlying Agreement.

c. **Effect of Termination.**

(1) Termination of this Addendum will result in termination of the Underlying Agreement.

(2) Upon termination of this Addendum or the Underlying Agreement, unless specially required by the Department for the business associate to retain the protected health information, the Business Associate will return or destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department, that the Business Associate still maintains and retain no copies of such PHI. If such return or destruction is not feasible, the Business Associate will extend the protections of this Addendum to the PHI and limit any further uses and disclosures. The Business Associate will provide the Department in writing the reason that will make the return or destruction of the information infeasible.

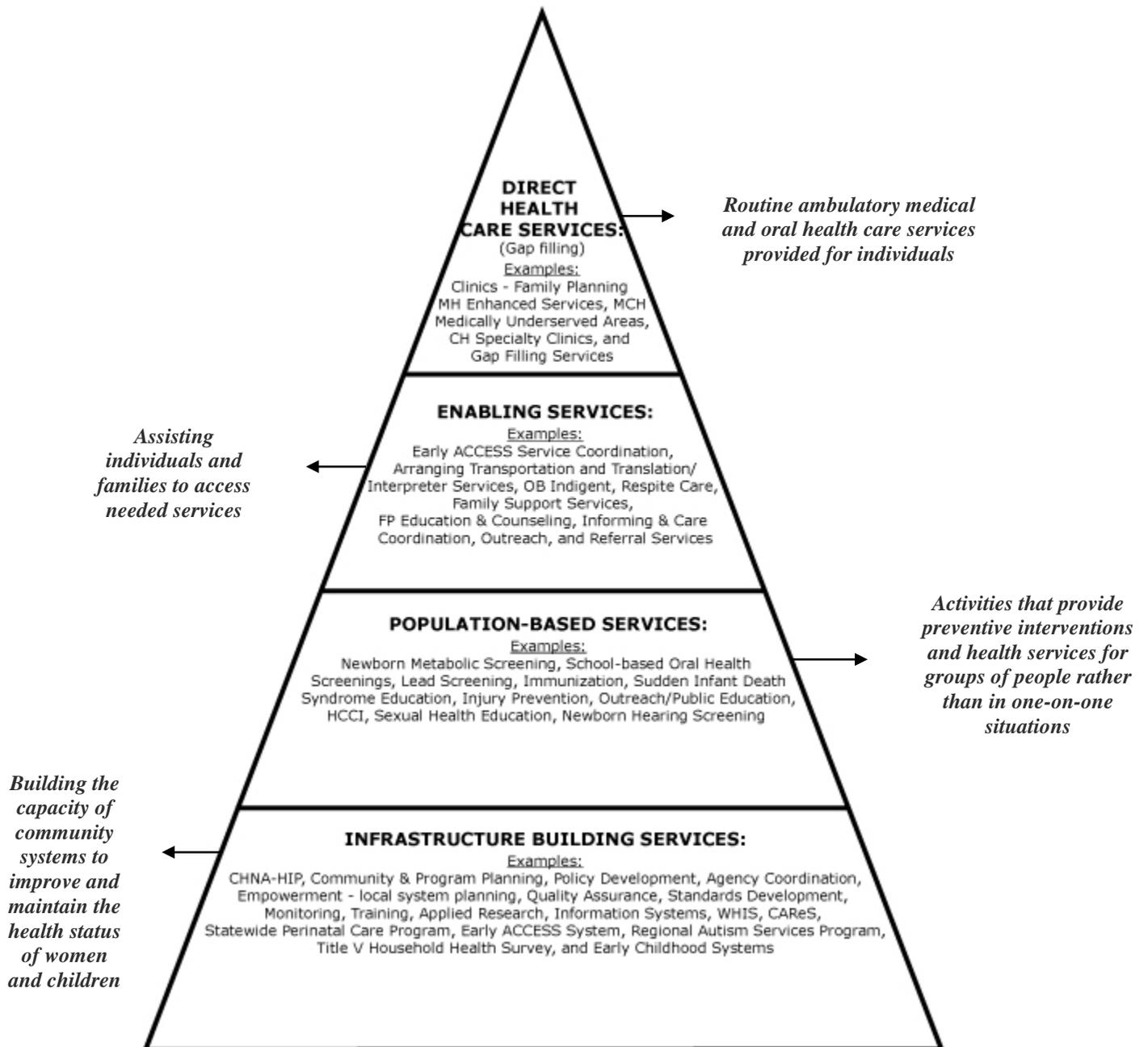
6. Amendment. The Department and the Business Associate agree to take such action as is necessary to amend this Addendum from time to time as is necessary for the Business Associate to comply with the requirements of the Privacy Rule and/or the Security Rule.

7. Survival. The obligations of the Business Associate under section 5.c.(2) of this Addendum shall survive any termination of this addendum.

8. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon a person other than the parties and their respective successors or assigns, an rights, remedies, obligations or liabilities whatsoever.

9. Effective Date. This Addendum shall be effective on 07/01/08.

Appendix A8: MCH Pyramid of Core Public Health Services



Appendix A9: Remittance of Interest Earned

REMITTANCE OF INTEREST EARNED

Contractor: _____

Program Title: _____

Contract #: _____

Reporting Period: _____
(must be reported at least quarterly)

***Amount of interest earned in advance this period:** \$ _____

***Amount of check submitted with this form:** \$ _____

Amount of interest earned (contract period to date): \$ _____

Amount remitted to IDPH (contract period to date): \$ _____

***Any difference between these two monetary amounts must be explained below.**

Authorized Contractor Signature: _____

Date: _____ **Phone:** _____

Appendix A10: Agency Administrative On-Site Review

Agency: _____

Programs: WIC MH CH FP

Date of on-site review: _____

Agency staff consulted: _____

Department reviewer: _____

Date of last administrative review: _____

List any recommendations and requirements from previous administrative reviews that are still unmet:

Yes No N/A

I. Organizational Chart:

A. Documents on file are consistent with current organizational structure.

B. Actual lines of supervision are reflected.

C. Agency has notified the Department, in writing, of required staff changes.

II. Agency lines of Communication and/or Management:

A. How often are agency staff meetings held? _____

B. How are staff minutes dispersed to staff? _____

C. How often are meetings with subcontractors held? _____

D. How are subcontractor meeting minutes dispersed? _____

III. Subcontractors:

A. Agreements, contracts, and memoranda of understanding have been signed for current grant year prior to effective date. (Check against the Subcontracts form of Agency's application)

B. Subcontracts are in compliance with Article 5 of the General Conditions dated October 1, 2009.

C. For Subcontracts, the qualifications and responsibilities are stipulated in the contract, or with contracted providers, as required by Americans with Disabilities Act of 1990 (ADA).

IV. Licensure:

- A. Agency has on file verification of current licensure status of professional staff, including contracted staff.

V. OSHA Bloodborne Pathogens Standards:

- A. Agency exposure control plan meets all of the OSHA Bloodborne Pathogens Standards.
- B. Employees directly exposed to bloodborne pathogens signed the "Hepatitis B Immunization Consent/Refusal Form".
- C. Agency conducts training and education (at the time of hire and annually thereafter) concerning bloodborne pathogen exposure.
- D. Records of training are kept for at least three years.

VI. Personnel Policies:

- A. Conditions of employment include recruitment, selection, termination, promotion, and compensation (including fringe benefits)
- B. Leave and absence.
- C. Grievance procedure.
- D. Provision for career development or continuing education.
- E. Nondiscrimination policy, to be consistent with Title VI of the Civil Right Act, Section 504 of the Rehabilitation Act of 1973, and Title I of the Americans with Disabilities Act.
- F. Employee orientation program.
- G. Employee performance evaluation.
- H. Policies reviewed according to the agency policy and updated as needed.

VII. Employee/Personnel Files:

- A. Employee performance review in employee personnel files is in compliance with Employee Performance Evaluation Policy. (Randomly select a representative sample of MCH personnel files and all Family Planning files)
- B. Confidentiality of personnel records are ensured in what way(s)?

Locked cabinet? Yes No

VIII. Employment Application Form:

- A. Form is in compliance with civil rights regulations.
- B. Form includes a detachable demographic data sheet.

XIII. Fiscal Policies and Control:

- A. The agency fiscal year covers the following time period: _____
- B. The agency tracks interest earned on advances.
- C. The agency remits such interest, at least quarterly, to the Department.
- D. A system to compare actual vs. budgeted expenditures is in place.
- E. Monthly reports of budgeted and actual expenditures are reviewed and approved.
- F. Allocating administrative and/or indirect costs charged to the program has a valid methodology.
1. Cost allocation plan is current.
2. Supporting documentation is available.
3. WIC and/or MCH funds pay for a vehicle lease arrangement.
4. The terms of the lease comply with federal policies.
- G. Agency personnel perform all accounting functions.
- H. MCH billing procedures for third party payers and other funding sources are in place.
- I. MCH and FP programs have a sliding fee scale.
- J. Patient bills show total cost of services and fees based on the sliding fee scale, as applicable.
- K. Sliding fee scale is applied after payment from other sources is received.
- L. The methodology for deferring fees meets program requirements.

XIV. Time Records:

- A. Continuous daily time studies are maintained.
- B. Time records allow reporting for more than one program.
- C. Time records accurately reflect total distribution of work time.
- D. Time studies and payroll records balance.
- E. All agency personnel keep time records.
- F. Time records are maintained, signed, and utilize a dual verification system.

XV. Expenditures and Documentation:

- A. External, agency-wide audit is conducted annually.
- B. Date of last Department fiscal audit: _____
- C. Chart of accounts is current.

- D. Monthly expenditure reports are prepared, signed properly, and submitted to the Department.
- E. Expenditures are within contractual and budgeted parameters.
- F. Monthly expense reports and agency ledgers match.
- G. All prior approval budget revisions have been submitted to the Department.

Child Health Only:

XVI. Child Health & Early Periodic Screening Diagnosis and Treatment:

- A. Protocols in the EPSDT Handbook:
 - Informing services
 - Care coordination services
- B. Date of last protocol review: _____
- C. Protocols shared on a regular basis with staff and subcontractors.

WIC Only:

XVII. WIC Agency:

- A. WIC Agency is in compliance with the Voter Registration Act of 1993.

XVIII. WIC Nutrition Education and Breastfeeding Documentation

- B. Supporting documentation is adequate for WIC Nutrition Education and Breastfeeding Documentation.
 1. Time studies and time certificates are current for all required staff and contracted personnel.
 2. Time is recorded appropriately on daily and monthly summary report.
 3. Time is being calculated and charged correctly.
 4. The year-to-date percentage of total expenditure in nutrition education and breastfeeding is at least 20%.
 - Breastfeeding- 3
 5. Breast pumps are purchased with food funds (not NSA).

XIX: Inventory Control

- C. WIC's infant formula sample inventory and/or issue log is maintained in a current and accurate manner.
- D. A specified person has been named as responsible for maintaining the log.

XX. In the exit interview, recommendations and requirements from this review were orally presented to management staff of:

Requirements

Recommendations

To assist with your planning for the On-Site Review, this listing of documents should be available during the review:

- Current table(s) of organization
- Administrative and personnel policies and procedures
- Verification of current licensure status of professional staff
- Current job descriptions for each budgeted position
- Current salary schedule
- Employee performance evaluation form
- Employment application form
- Time sheets/time studies
- Affirmative action plan
- Verification of compliance with OSHA bloodborne pathogens standards and the Americans with Disabilities Act of 1990
- Clinic site accessibility evaluation documentation
- Equipment inventory list and procedures
- Fiscal policies and procedures
- Fiscal records, chart of accounts, and support documentation
- Contract and budget file
- Vehicle lease agreement
- Contracts and agreements with other providers or agencies
- Rent leases/agreements and space cost allocation plan
- Cost allocation plan for shared costs
- MCH/FP sliding fee, billing, collection and bad debt policies
- Documentation of compliance with requirements of previous reviews.

Appendix A11: National Performance Measures, State Performance Measures, Outcome Measures

NATIONAL PERFORMANCE MEASURES	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.	X			
2) The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey)	X			
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)		X		
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)			X	
5) The percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)			X	
6) The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)			X	
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.			X	
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 yrs.			X	
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X	
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.			X	
11) Percentage of mothers who breast feed their infants at 6 mon of age.				X
12) Percentage of newborns who have been screened for hearing before hospital discharge.				X
13) Percent of children without health insurance.				X
14) Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85 th percentile.				X
15) Percent of women who smoke in the last three months of pregnancy.				X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X

NOTE: **DHC** = Direct Health Care **ES** = Enabling Services **PBS** = Population Based Services **IB** = Infrastructure Building.

STATE PERFORMANCE MEASURES	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The degree to which the state MCH Title V Program improves the system of care for mothers and children in Iowa.				X
2) The degree to which components of a coordinated statewide system of care for children and youth with special health care needs are implemented.		X		X
3) The degree to which Iowa's state MCH Title V program addresses health equity in MCH programs.		X		X
4) Percent of family planning clients (women and men) who are counseled about developing a reproductive life plan.	X			
5) The degree to which the health care system implements evidence-based prenatal and perinatal care.	X	X		
6) Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy.	X	X	X	X
7) Percent of Medicaid enrolled children ages 0-5 years who receive a dental service.	X	X	X	X
8) Rate of hospitalizations due to unintentional injuries among children ages 0-14 years.		X	X	X

NOTE: **DHC** = Direct Health Care **ES** = Enabling Services **PBS** = Population Based Services **IB** = Infrastructure Building.

Number	Outcome Measure
1	The infant mortality rate per 1,000 live births.
2	The ratio of the black infant mortality rate to the white infant mortality rate.
3	The neonatal mortality rate per 1,000 live births.
4	The postneonatal mortality rate per 1,000 live births.
5	The perinatal mortality rate per 1,000 live births plus fetal deaths.
6	The child death rate per 100,000 children aged 1-14.

Appendix A12: CDC Growth Charts

Growth charts consist of a series of percentile curves that illustrate the distribution of selected body measurements in U.S. children. Pediatric growth charts have been used by pediatricians, nurses, and parents to track the growth of infants, children, and adolescents in the United States since 1977. The first growth charts were developed by the National Center for Health Statistics (NCHS) as a clinical tool for health professionals to determine if the growth of a child is adequate. They were also adopted by the World Health Organization for international use. The charts were updated in 2000 and consist of 16 charts (eight for boys and eight for girls). Growth charts are not intended to be used as a sole diagnostic instrument. Instead, they are tools that contribute to forming an overall clinical impression for the child being measured.

Growth charts are published by the Centers for Disease Control and Prevention (CDC) at <http://www.cdc.gov/growthcharts>. The following presents web links to clinical growth charts for children birth to 36 months and age 2 to 20 years (both boys and girls).

Growth Charts for Birth to 36 months

Boys Length-for-age & Weight-for-age chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411017.pdf
Boys Head circumference-for-age & Weight-for-length chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411019.pdf
Girls Length-for-age & Weight-for-age chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411018.pdf
Girls Head circumference-for-age & Weight-for-length chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411020.pdf

Growth Charts for age 2-20 years

Boys Stature-for-age and Weight-for-age chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411021.pdf
Boys Body mass index-for-age chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411023.pdf
Girls Stature-for-age and Weight-for-age chart	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411022.pdf
Girls Body mass index-for-age chart found at:	http://www.cdc.gov/nchs/data/nhanes/growthcharts/set1clinical/cj411024.pdf

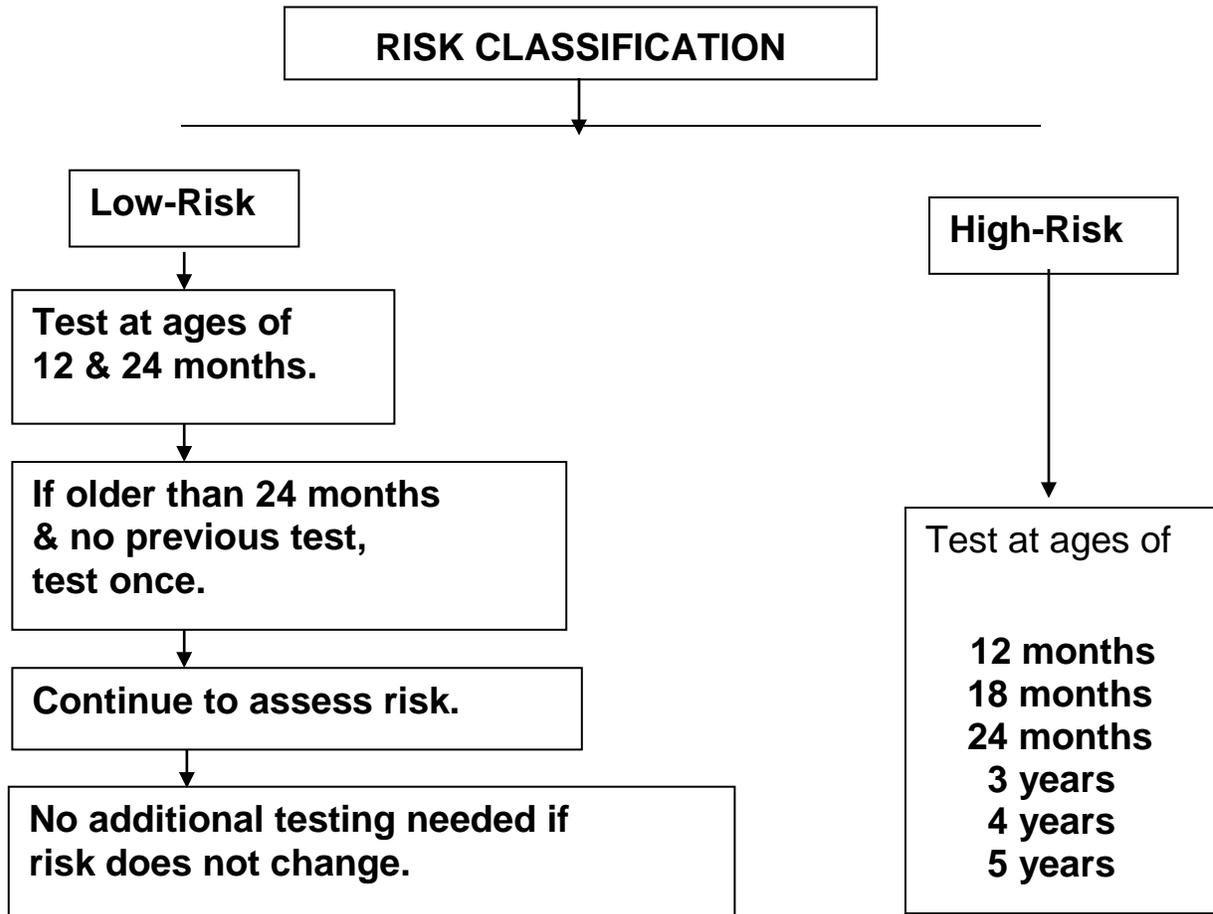
Appendix A13: Childhood Lead Poisoning Risk Questionnaire

Date: _____
 Name: _____
 Address: _____
 Date of Birth: _____

If the answer to any of these questions is “yes”, the child is considered to be at high risk for lead poisoning and must be screened according to the high-risk screening schedule. If the parent does not know the answer to a question, the answer should be assumed to be “yes.” This questionnaire should be reviewed at each regular visit. Write additional dates that the questionnaire is reviewed in the blank for "date" and note any changes to the answers.

1. Has your child **ever** lived in or regularly visited a house built before 1960? Yes No
 (Examples: home, day-care center, baby-sitter, relative's home)
2. Have you noticed any peeling or chipping paint in or around the pre-1960 house that your child has lived in or regularly visited? Yes No
3. Is the pre-1960 home that your child has lived in or regularly visited been remodeled or renovated by: Yes No
 A. Stripping, sanding, or scraping paint on the inside or outside of the house.
 B. Removing walls and/or tearing out lath and plaster.
4. Does your child eat non-food items such as dirt? Yes No
5. Have any of your other children or their playmates had lead levels $\geq 15 \mu\text{g/dL}$? Yes No
6. Does your child live with or frequently come in contact with an adult who works with lead on the job or in a hobby? (Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramics worker, stained glass worker, sheet metal worker, scrap metal worker, plumber.) Yes No
7. Does your child live near a battery plant, battery recycling plant, or lead smelter? Yes No
8. Do you give your child any home or folk remedies? (Examples: azarcon, greta, pay-loo-ah) Yes No
9. Does your child eat candy that comes from Mexico or southeast Asia? Yes No
10. Has your child ever lived in Mexico, Central America, South America, Africa, Asia, or eastern Europe, or visited one of these areas for a period longer than two months? Yes No

Appendix A14: Basic Lead Testing Chart (Based on Risk and Age)



Appendix A15: Guidelines for Detection and Management of Asymptomatic Lead-Poisoned Children

For Physicians and Health Care Providers

BLOOD LEAD LEVEL in $\mu\text{g}/\text{dL}$ (micrograms per deciliter)	TREATMENT	COMMENT
<10 $\mu\text{g}/\text{dL}$	<ul style="list-style-type: none"> Continue routine blood lead testing. (See Iowa Basic Lead Testing Chart.) 	<ul style="list-style-type: none"> Child is not lead-poisoned.
10-14 $\mu\text{g}/\text{dL}$ (capillary or venous)	<ul style="list-style-type: none"> Capillary or venous retest within three months. Test for iron deficiency using hematocrit or hemoglobin. 	<ul style="list-style-type: none"> Provide information to family regarding lead poisoning, importance of good nutrition, and housekeeping.
≥ 15 $\mu\text{g}/\text{dL}$ (capillary)	<ul style="list-style-type: none"> Order venous blood lead level. 	<ul style="list-style-type: none"> Further action based on venous blood lead level.
15-19 $\mu\text{g}/\text{dL}$ (venous)	<ul style="list-style-type: none"> Venous retest in 3 months. Test for iron deficiency using hematocrit or hemoglobin. 	<ul style="list-style-type: none"> Refer to dietician for nutrition evaluation. Refer for public health nursing visit. Environmental investigation by public health agency after 2 venous levels of 15-19 $\mu\text{g}/\text{dL}$.
20-44 $\mu\text{g}/\text{dL}$ (venous)	<ul style="list-style-type: none"> Pediatric evaluation. Venous retest in 4 to 6 weeks. Test for iron deficiency using serum iron and iron binding capacity or serum ferritin. 	<ul style="list-style-type: none"> Refer to dietician for nutrition evaluation. Refer for public health nursing visit. Environmental investigation by public health agency.
45-69 $\mu\text{g}/\text{dL}$ (venous)	<ul style="list-style-type: none"> Pediatric evaluation. Test for iron deficiency using serum iron and iron binding capacity or serum ferritin. Inpatient or outpatient chelation.* Venous retest before chelation, at the end of chelation, and 21 days after chelation. Public health agency must verify that home is lead-safe for outpatient chelation. 	<ul style="list-style-type: none"> Refer to dietician for nutrition evaluation. Refer for public health nursing visit. Environmental investigation by public health agency.
≥ 70 $\mu\text{g}/\text{dL}$ (venous) MEDICAL EMERGENCY!!	<ul style="list-style-type: none"> Pediatric evaluation. Test for iron deficiency using serum iron and iron binding capacity or serum ferritin. Inpatient chelation.* Venous retest before chelation, at the end of chelation, and 7 days after chelation. Public health agency must verify that home is lead-safe before child returns home. 	<ul style="list-style-type: none"> Refer to dietician for nutrition evaluation. Refer for public health nursing visit. Environmental investigation by public health agency.

*For detailed recommendations regarding chelation, contact the Iowa Statewide Poison Control Center at 1-800-222-1222. Rev. 7/2001

Appendix A16: Maternal Health Services Consent Form

Name of Agency
Maternal Health Services
Consent Form

Client Name:	Date of Birth:
Address:	Phone:
Title XIX # :	

I, _____ give _____
Print name of client Print name of agency

consent to provide me and my baby with Maternal Health Services by a Registered Nurse, Social Worker, or Registered Dental Hygienist or other agency staff.

Maternal Health Services may include the following:

Education/Anticipatory Guidance
 Assistance Getting Doctor or Dentist
 Assistance Getting Insurance
 Assistance Linking to Community Resources
 Assistance Getting Transportation
 Nutrition Education
 Prenatal Home Visits
 Postpartum Home Visit (will include assessment of both mother and baby)
 Psychosocial Assessment
 Preventive Oral Health Services (including screening and fluoride varnish application)

- I received a Notice of Privacy Practices on _____. (*insert date*)
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand that records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureau of Family Health or Bureau of Oral and Health Delivery Systems), Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

This consent for services is valid for one year unless withdrawn in writing by client.

Signature of Client

Date

Appendix A17: Child Health Services Consent Form

Name of Agency
Child Health Services
Consent Form

Client Name:	Date of Birth:
Address:	Phone:
Title XIX #:	

I, _____ give _____

Print name of client Print name of agency

consent to provide my child with Child Health Services by a Registered Nurse, Social Worker, or other qualified staff.

Child Health Services may include the following *(edit as needed for your program)*:

Education/Anticipatory Guidance
Assistance Getting a Doctor or Dentist
Assistance Getting Insurance
Assistance Linking to Community Resources
Assistance Getting Transportation
Assistance Getting Interpreter Services
Referral and other care coordination services
Capillary blood draws and lead poisoning prevention education
Immunizations
Developmental screenings

- I received a Notice of Privacy Practices on _____. *(insert date)*
- I understand that these services are provided through the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand that records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureau of Family Health or Bureau of Oral and Health Delivery Systems), Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

This consent for services is valid for one year unless withdrawn in writing by parent, or guardian, or client (if of legal age).

Signature of Parent, Guardian, or Client (if of legal age)

Date

Appendix A18: Release of Information Form

Release of Information Form

AUTHORIZATION TO RELEASE, OBTAIN, OR EXCHANGE INFORMATION

AGENCY NAME: _____

AGENCY ADDRESS: _____

CLIENT NAME: _____ CLIENT CHART NUMBER: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

DATE OF BIRTH: _____

Reason for request to release information: _____

I VOLUNTARILY AUTHORIZE (*insert MCH agency name*) _____ staff to release, obtain, or exchange information with the following agencies:

NAME/AGENCY	ADDRESS	PHONE

I authorize the release and exchange of the following information:

- General Medical Care: _____
 School Records: _____
 Social and Family History: _____
 Other: _____

Specific Authorization for Release of Information Protected by State or Federal Law :

I acknowledge that information to be released may include material that is protected by federal and/ or state law applicable to substance abuse, mental health, and/ or HIV/AIDS – related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Please check the applicable boxes.]

Mental Health* yes no

Substance Abuse** yes no

HIV/AIDS yes no

Signature: _____

Patient Signature: _____

Signature: _____

Relationship: _____

Relationship: _____

Note in order for this information to be released you must sign here and on the bottom of this page:

Signature: _____

*Only client 18 years of age or emancipated teenager, or legal representative can authorize release of mental health information.

**Only client, regardless of age, can authorize release of substance abuse information.

I UNDERSTAND that the AUTHORIZATION TO RELEASE, OBTAIN, OR EXCHANGE INFORMATION form is limited to the agencies, groups, or persons named; and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. However, any information already released may be used as stated on this authorization form. I understand the information is needed to plan services or to determine eligibility for services. This authorization is effective for no longer than one year from the date of signature or for _____ months. This authorization is not automatically renewable. It expires from the date of signature. I have read this release or it has been read to me, and I understand its content. Photocopies of this release will be as valid as the original.

I certify that any person(s) who furnish such information concerning me shall not be held accountable for providing this information, and I do hereby release said person(s) from any and all liability which may be incurred as a result. I further release the Iowa Department of Public Health from any and all liability which may be incurred as a result of collecting or disclosing such information.

Note: See disclosure and re-disclosure on back side of this page before signing.

Signature of Client or Representative: _____ Date: _____

Relationship of Authorized Representative: _____ Date: _____

Disclosure and Re-disclosure

Iowa and federal law provides that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit additional disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

See also Iowa Code Chapters 141A and 228.0 and other applicable laws.

This form does not authorize re-disclosure of medical information beyond the limits of the consent.

Appendix A19: Intimate Partner Violence, Reproductive Coercion and Human Trafficking

Resources

Resources

- *Reproductive Health and Partner Violence Guidelines: An Integrated Response to Intimate Partner Violence and Reproductive Coercion*
www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf
- Polaris Project for a World Without Slavery:
www.polarisproject.org/index.php. and
www.polarisproject.org/state-map/iowa
- Human Trafficking hot line 1-888-373-7888
- Administration for Children & Families. Look Beneath the Surface: Human Trafficking is Modern-Day Slavery:
www.acf.hhs.gov/trafficking/index.html.
- Administration for Children & Families: Rescue and Restore Coalition www.acf.hhs.gov/trafficking/rescue_restore/index.html and www.acf.hhs.gov/trafficking/about/coalition_list.html.
- Iowa Code 728.12 - Sexual exploitation of a minor
- Iowa Code 701A – Human Trafficking
- **Network Against Human Trafficking (Iowa-based):**
www.iowanaht.org

Intimate Partner Violence and Reproductive Coercion Creating a Local Agency Resource Sheet

Call local programs and find out what services are offered:

- Crisis hotline
- Individual counseling
- Case management
- Support groups
- Emergency shelter (are children allowed? What ages? Boys and girls?)
- Transitional housing
- Housing advocacy
- Transportation vouchers
- Legal advocacy- police & court accompaniment, restraining order assistance, law clinics
- Hospital accompaniment (for sexual assault exams)
- Court-mandated counseling programs (parenting, batterer's intervention)
- Counseling for child witnesses to violence
- Services for adolescents
- Services for LGBT community
- On-site health services
- Community education/outreach
- Children's programming offered?
- Other:

What languages are spoken?

Do they have any other culturally specific programs?

Are they near public transit or do they offer transportation services?

Is there any cost for services?

Are there evening hours?

Are there any restrictions for receiving services (sobriety, active restraining order, etc.)?

Do they currently or would they be willing to provide training to community members?

Ask if there is anything else you should know about their services and explain why you are calling.

Identify a key contact for your work and for the family planning or home visitors you are training.

Appendix A20: Early ACCESS Service Coordination Checklist

 Child Health Early ACCESS EPDST Service Coordination Checklist FY 11		
Child's Name:		
Notes:		
Date of Referral:		45 Day Time Line Ends:
Date	Activity	Notes
Referral		
	<ul style="list-style-type: none"> • Complete Intake/Referral Page (Link to template on internet: Intake/Referral February 2010) • Call AEA Regional Liaison to see if child is already receives services from AEA <ul style="list-style-type: none"> ⇒ If yes, contact referral source and inform that the family is already receiving Early ACCESS ⇒ If no, Send Intake/Referral Page to IDPH Early ACCESS consultant via email or fax. IDPH will enter intake into web IFSP system and assign child to Service Coordinator's caseload. Service Coordinator will then.... 	
Initial Contact with Family		
	<ul style="list-style-type: none"> • Contact family <ul style="list-style-type: none"> ⇒ Introduce and explain program ⇒ Schedule home visit • If family accepts Early ACCESS, begin a meeting in the web IFSP so that you have access to Service Coordination Log- Record all contact/visits in Service Log on the web. • If family declines Early ACCESS, notify IDPH Early ACCESS consultant and inform IDPH of date spoke to family. IDPH consultant will edit intake and close referral form (this will remove child from your caseload). 	
Prior to Initial Home Visit		

	<ul style="list-style-type: none"> In the web IFSP, go to <i>forms</i> tab, load Exchange of Information (load at minimum 3 exchanges one for Lead Program, physician, AEA, and anyone additional) and Health Release (if needed). Print exchanges and release for parent signature at first home visit. 	
Initial Home Visit		
	<ul style="list-style-type: none"> Provide Manual and “quick guide” of Parental Rights and Procedural Safeguards (Link to manual on the internet Part C Parental Rights Manual (2006-6-21)) 	
	<ul style="list-style-type: none"> Complete Consent for Evaluation form- requires Parent/Guardian signature (Link to Consent: EA Consent for Evaluation with PWN August 2008) 	
	<ul style="list-style-type: none"> Parent/Guardian signs Exchange of Information forms. (if you didn’t generate the exchanges in the child’s web IFSP, take blank exchanges, fill out and have signed. (Link to exchange: Exchange of Information August 2008) 	
	<ul style="list-style-type: none"> Complete Release of Health Information form, if needed- requires Parent/Guardian signature (if you didn’t generate the health release in the child’s web IFSP, take blank release, fill out and have signed. (Link to release: Health Info Release August 2008) 	
	<ul style="list-style-type: none"> Complete Medicaid Parent Authorization form- planning for next 6 months of service- requires Parent/Guardian signature (link: Medicaid Parent Authorization Form August 2008) 	
	<ul style="list-style-type: none"> In web IFSP enter information in the <i>Family</i> tab. If you’re not online when in the home, here is a template of information you need to collect to enter into web IFSP (link: Family Information February 2010) 	
	<ul style="list-style-type: none"> In web IFSP enter information in the <i>Family Statements</i> tab. If you’re not online when in the home, here is a template of information you need to collect to enter into web IFSP (Link: Family Statements August 2008) 	
	<ul style="list-style-type: none"> Complete the Race/Ethnicity Verification Form- whomever makes the determination of Race/Ethnicity signs the form. (Link: Race and Ethnicity Letter February 2010) 	
Initial Visit Follow Up		
	<ul style="list-style-type: none"> Request health information from physician, and let them know involvement with the family Request summary of the lead inspection report from Lead Program 	

	<ul style="list-style-type: none"> In child's web IFSP complete entry of information if you used Family Information and Family Statements templates during home visit Record activities in Service Log in web IFSP. Search for child in CAREs or create a new record in CAREs for child and record information 	
MONTH 1		
Evaluation Home Visit		
Pre Meeting		
	<ul style="list-style-type: none"> Record review (Lead program/doctor files/hearing/vision tests) <ul style="list-style-type: none"> If newborn hearing test is more than 1 year old, schedule a hearing eval at local AEA. A hearing test should be completed prior to Initial IFSP meeting. summary of the lead inspection report medical records 	
Evaluation Home Visit		
	Developmental Evaluation- 5 domains	
	<ul style="list-style-type: none"> Complete DAYC tool 	
	<ul style="list-style-type: none"> Score and explain results to family ⇒ If DAYC scores are in the lower "pink" contact the AEA to discuss possible need for additional evaluation(s). 	
	<ul style="list-style-type: none"> In child's web IFSP Complete <i>Eval/Assess</i> tab 	
Initial IFSP Meeting (within 45 Days of referral- if 45 day timeline missed, document reason on IFSP Meeting Details)		
Pre Meeting		
	<ul style="list-style-type: none"> 2 weeks prior to Initial IFSP Meeting, Send Meeting Notice to participants (Generate the meeting notice in the child's web IFSP, go to <i>Forms</i> tab and load Meeting Notice). Invite IFSP team, include: parent(s), Lead program, Medical provider, community providers {DHS, Head Start, etc}, and anyone family requests. 	
Initial IFSP Meeting		
	<ul style="list-style-type: none"> In child's web IFSP complete information on <i>Meeting</i> tab. If you are not online during Initial IFSP Meeting, you can use the Meeting Details template as a guide of information to be completed. (Link: Meeting Details August 2008) 	
	<ul style="list-style-type: none"> In child's web IFSP load and complete <i>Outcomes</i> tab. If you are not online during Initial IFSP Meeting, you can use the Outcomes template as a guide of information to be completed. (Link: Outcomes February 2010) 	
	<ul style="list-style-type: none"> In child's web IFSP go to <i>Forms</i> tab and load 	

	the Early Childhood Outcomes (ECO) form and complete.	
	<ul style="list-style-type: none"> In child's web IFSP go to <i>Services</i> tab and fill in fields for services child is going to receive: <ul style="list-style-type: none"> Service: Service Coordination Location: Home *if not meeting family at home must justify why Method: Individual With Whom: Child/Adult Frequency: 1 six month period Intensity: try to estimate the total number of billable minutes you will work with the family in the upcoming 6 months Start date: Fill in with date of Initial IFSP meeting Expected Duration: 6 months If other Early Intervention services are provided that help family meet an Outcome (i.e. Speech from AEA), add service and provider (this give person access to web IFSP) If family is receiving a non Early Intervention service and the service contributes to an outcome (i.e. WIC, Lead Case Management) then it will be added as OE or OH service. 	
	<ul style="list-style-type: none"> If you had any changes to the amount or type of services provided to family than a new Medicaid Parent Authorization must be completed- requires Parent/Guardian signature (Link: Medicaid Parent Authorization Form August 2008) 	
	<ul style="list-style-type: none"> Complete Consent for Early ACCESS Services form- check "initial" box. Obtain Parent/Guardian signature- signature shows family agreement to services. This form is not available in web IFSP, here is link: Consent for Early ACCESS Services February 2010 	
	<ul style="list-style-type: none"> Review Parental Rights and Procedural Safeguards 	
	<ul style="list-style-type: none"> Record activities in web IFSP on Service Log Record activities in CARES 	
Initial IFSP Meeting Follow Up		
	<ul style="list-style-type: none"> In child's web IFSP go to <i>Forms</i> tab and load Prior Written Notice (PWN). Complete the form for initiation of service, state results of DAYC evaluation and services to be provided. 	
	<ul style="list-style-type: none"> Send copy of Initial IFSP and Prior Written Notice to Family and other IFSP participants. 	

	<ul style="list-style-type: none"> • Send copy of IFSP Early Intervention (EI) Services page and copy of DAYC Evaluation Tool Summary to physician and Regional Lead program 	
	<ul style="list-style-type: none"> • Contact IDPH Early ACCESS consultant to discuss what/if any copies need to go to the AEA. Each AEA is doing things differently. 	
	<ul style="list-style-type: none"> • Connect families with services identified in IFSP 	
	<ul style="list-style-type: none"> • Record activities in web IFSP on Service Log • Record activities in CAREs 	
	<p>Once all information is entered into web IFSP, notify IDPH Early ACCESS consultant. Consultant will review your child’s IFSP online. Once reviewed the consultant will provide feedback and notify you to submit the web IFSP. Once the IFSP is submitted the AEA will implement the IFSP. Once the IFSP is implemented no changes can be made to that IFSP, however you can continue to add notes to Service Coordinator Log in an implemented IFSP.</p>	
MONTH 2		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> • Call family to check in, see if any new needs and/or concerns • Record contact in web IFSP in Service Log • Record activities in CAREs 	
MONTH 3		
Quarterly Home Visit		
	<p>Developmental Evaluation/ Optional</p> <ul style="list-style-type: none"> • Send copy of Evaluation Tool Summary to Lead program 	
	<ul style="list-style-type: none"> • Identify & Link family with appropriate community resources. Provide education on development & developmental activities. 	
	<ul style="list-style-type: none"> • Record visit in web IFSP in Service Log • Record activities in CAREs 	
MONTH 4		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> • Call family to check in, see if any new needs and/or concerns • Record contact in web IFSP in Service Log • Record activities in CAREs 	
MONTH 5		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> • Call family to check in, see if any new needs and/or concerns 	

	<ul style="list-style-type: none"> • Record contact in web IFSP in Service Log • Record activities in CAREs 	
MONTH 6		
Periodic Review/Quarterly Home Visit		
Pre Meeting		
	In child's web IFSP click 'Pre Plan" button. Then Click the <i>Meeting</i> tab, a box will pop up asking if this is a periodic meeting- click YES.	
	<ul style="list-style-type: none"> • Send Meeting notice (2 weeks prior) go to <i>Forms</i> tab in web IFSP and generate the notice. 	
Periodic Review/Quarterly Home Visit		
	<ul style="list-style-type: none"> • Administer DAYC- all 5 domains ⇒ Enter summary of results in <i>Eval/Assess</i> tab of web IFSP. ⇒ Contact AEA if DAYC scores are in lower "pink" to see if additional evaluations needed 	
	<ul style="list-style-type: none"> • Complete <i>Meeting</i> Tab- be sure to fill in the correct Date of Meeting 	
	<ul style="list-style-type: none"> • If changes to demographics information – make changes on <i>Family</i> Tab in web IFSP 	
	<ul style="list-style-type: none"> • Update progress on current IFSP Outcomes- go to <i>Outcomes</i> Tab, at bottom click <i>Outcome Progress</i> button. 	
	<ul style="list-style-type: none"> • If new IFSP Outcomes is identified, load new Outcome in web IFSP and complete. 	
	<ul style="list-style-type: none"> • Go to <i>Services</i> tab in web IFSP adjust minutes as needed. 	
	<ul style="list-style-type: none"> • Complete Medicaid Parent Authorization, this will reflect the new services being billed for next 6 months- requires parent signature (Link: Medicaid Parent Authorization Form August 2008) 	
	<ul style="list-style-type: none"> • If a new service will begin, a current service is discontinued, or service frequency or duration changes. PWN must be completed in web IFSP and provided to family. 	
	<ul style="list-style-type: none"> • If you give the family a PWN then must also complete Consent for Early ACCESS Services- check "periodic" box, obtain Parent/Guardian signature- signature shows family agreement to services. (Link: Consent for Early ACCESS Services February 2010) 	
	<ul style="list-style-type: none"> • Record visit in web IFSP in Service Log • Record activities in CAREs 	
Periodic Review/Quarterly Home Visit Follow Up		
	<ul style="list-style-type: none"> • Send copy of Periodic IFSP to family and other IFSP team participants 	

	<ul style="list-style-type: none"> Once all information is entered into web IFSP, notify IDPH Early ACCESS consultant. Consultant will review periodic IFSP. The consultant will provide feedback and notify you to submit the periodic. Once submitted the AEA will implement the IFSP. No changes can be made to implemented IFSP, however you can continue to add notes to Service Log. 	
	<ul style="list-style-type: none"> Contact IDPH Early ACCESS consultant to discuss what/if any copies need to go to the AEA. Each AEA is doing things differently 	
	<ul style="list-style-type: none"> Record activities in web IFSP in Service Log Record activities in CAREs 	
MONTH 7		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> Call family to check in, see if any new needs and/or concerns Record contact in web IFSP in Service Log Record activities in CAREs 	
MONTH 8		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> Call family to check in, see if any new needs and/or concerns Record contact in web IFSP in Service Log Record activities in CAREs 	
MONTH 9		
Quarterly Home Visit		
	Developmental Evaluation/ Optional <ul style="list-style-type: none"> Send copy of Evaluation Tool Summary to Regional Lead Program 	
	<ul style="list-style-type: none"> Identify & Link family with appropriate community resources. Provide education on development & developmental activities. 	
	<ul style="list-style-type: none"> Record contact in web IFSP in Service Log Record activities in CAREs 	
MONTH 10		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> Call family to check in, see if any new needs and/or concerns Record contact in web IFSP in Service Log Record activities in CAREs 	
MONTH 11		
Monthly Contact/Monthly Service Coordination		
	<ul style="list-style-type: none"> Call family to check in, see if any new needs and/or concerns Record contact in web IFSP in Service Log Record activities in CAREs 	

MONTH 12	
Annual IFSP Meeting/Quarterly Home Visit	
Pre Meeting	
	In child's web IFSP click 'Pre Plan" button. Then Click the <i>Meeting</i> tab, a box will pop up asking if this is a periodic meeting- leave blank, do not click YES.
	<ul style="list-style-type: none"> • Send Meeting Notice (2 weeks prior)
	<ul style="list-style-type: none"> • In the web IFSP, go to <i>Forms</i> tab, load Exchange(s) of Information and Health Release (if needed). Print exchanges and release for parent signature at first home visit- these have to be signed annually.
Annual IFSP Meeting/Quarterly Home Visit	
	<ul style="list-style-type: none"> • Administer DAYC- all 5 domains ⇒ Enter summary of results in <i>Eval/Assess</i> tab of web IFSP. ⇒ Contact AEA if DAYC scores are in lower "pink" to see if additional evaluations needed
	<ul style="list-style-type: none"> • Complete <i>Meeting</i> Tab- be sure to fill in the correct Date of Meeting
	<ul style="list-style-type: none"> • If changes to demographics information – make changes on <i>Family</i> Tab in web IFSP
	<ul style="list-style-type: none"> • Complete <i>Family Statements</i> tab in the web. If you're not online when in the home, here is a template (Link: Family Statements August 2008)
	<ul style="list-style-type: none"> • Update progress on current IFSP Outcomes- go to <i>Outcomes</i> Tab, at bottom click <i>Outcome Progress</i> button.
	<ul style="list-style-type: none"> • If new IFSP Outcomes is identified, load new Outcome in web IFSP and complete.
	<ul style="list-style-type: none"> • In child's web IFSP go to <i>Forms</i> tab and load the Early Childhood Outcomes (ECO) form and complete.
	<ul style="list-style-type: none"> • Go to <i>Services</i> tab in web IFSP adjust minutes as needed. If new service is being added, you would add it here. If service is being ended, you would end it here.
	<ul style="list-style-type: none"> • Complete Medicaid Parent Authorization, this will reflect the new services being billed for next 6 months- requires parent signature (Link: Medicaid Parent Authorization Form August 2008)
	<ul style="list-style-type: none"> • If a new service will begin, or a current service is discontinued, or service frequency or duration changes. PWN must be completed in web IFSP and provided to family.
	<ul style="list-style-type: none"> • Complete Consent for Early ACCESS Services, obtain Parent/Guardian signature-

	signature shows family agreement to services, signed annually. (Link: Consent for Early ACCESS Services February 2010)	
	<ul style="list-style-type: none"> Family signs Authorization for Exchange of Information (signed annually) 	
	<ul style="list-style-type: none"> Family signs Authorization for Release of Health Information (signed annually if needed) 	
	<ul style="list-style-type: none"> Review Parental Rights/Procedural Safeguards 	
	<ul style="list-style-type: none"> Record visit in web IFSP in Service Log Record activities in CARES 	
Annual Meeting Follow Up		
	<ul style="list-style-type: none"> Send copy of Annual IFSP to family and other IFSP team participants 	
	<ul style="list-style-type: none"> Once all information is entered into web IFSP, notify IDPH Early ACCESS consultant. Consultant will review annual IFSP. The consultant will provide feedback and notify you to submit the annual. Once submitted the AEA will implement the IFSP. No changes can be made to implemented IFSP, however you can continue to add notes to Service Log. 	
	<ul style="list-style-type: none"> Contact IDPH Early ACCESS consultant to discuss what/if any copies need to go to the AEA. Each AEA is doing things differently 	
	<ul style="list-style-type: none"> Record activities in web IFSP in Service Log Record activities in CARES 	
<p>Transition planning begins when a child is 2yrs 3mo *Most likely a transition meeting will occur at the same time as a initial, periodic or annual meeting. *See Title V Early ACCESS Transition Guidance Document for Further Information.</p>		
	<ul style="list-style-type: none"> On the web IFSP (start your periodic or annual meeting) complete all needed activities for periodic or annual (activities are above). In addition Complete the <i>Transition</i> tab page 	
Final Exit at age 3		
	<ul style="list-style-type: none"> On the most current implemented IFSP plan add and complete a Prior Written Notice (Forms tab) that exits the child from Early ACCESS. Print copy to give to parent. 	
	<ul style="list-style-type: none"> Update progress on Outcomes. Include exit date on this form. 	
	<ul style="list-style-type: none"> Update service log in regards to child exiting. 	
	<ul style="list-style-type: none"> Proceed to the IFSP overview screen (Click on Birdhouse). On this screen, click EXIT to access the Final exit screen. 	

	<ul style="list-style-type: none"> • Very important! Verify the final exit day and edit as appropriate. 	
	<ul style="list-style-type: none"> • Check the status of the Tasks (Transition plan, Current Plan Implemented, Final ECO). Use the GO buttons to complete if incomplete. When a task is completed use the SAVE AND BACK TO EXIT button. Repeat as necessary until all TASKS are complete. (You may click on Final Exit Report button to view missing data report.) 	
	<p>STOP. Do not ever click the "Final Exit the Child" button. This button is visible after all tasks are completed. Do not fill in final Exit Code. This will be done by AEA personnel.</p>	
	<ul style="list-style-type: none"> • Print the completed transition plan from the GO button, hand write in Final Exit Date and Final Exit Reason and send to IDPH Consultant, who will work with AEA personnel. 	
	<ul style="list-style-type: none"> • Close the Final Exit Screen by clicking Caseload, Case list or Birdhouse. 	
	<ul style="list-style-type: none"> • Send entire original IFSP (or any original documents not previously submitted) to the AEA Regional Liaison- make copies for your records. 	
	<ul style="list-style-type: none"> • Record activities in CARES 	

Appendix A21: Early ACCESS Screening Center Services and Codes

Note: Agencies must bill their costs.

Service	Required Discipline	Code & Bill To	Max Rate/ Time Frame
Care Coordination	Licensed: RN, RD, or BA/BS Degree in: * Health Education * Social Work * Counseling * Nutrition * Sociology * Psychology	Bill to IDPH	9.46/ 15min
Home visit for Coordination of Care, lead follow-up, or medically necessary	Same as Above *Lead skilled nursing home visit must be an RN	Bill to IDPH	18.48/15min
Initial Nutrition Assessment and Counseling	Licensed Dietician	97802 Bill to IME	15.04/15min
Nutritional Reassessment and Counseling	Licensed Dietician	97803 Bill to IME	15.04/15min
EPSDT Local Transportation- Bill actual cost of transportation for the date the transportation was provided to the health related appointment, all are billed to IME.			
Bus round trip		A0110	Cost
Taxi round trip		A0100	Cost
Wheelchair van round trip		A0130	Cost
Per mile-volunteer, interested individual, neighbor		A0090	Cost
Min-bus /other non profit transportation system round trip		A0120	Cost

Screening Center Policy Manual is available on the web at:

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Provman/scenter.pdf

Screening Center Fee Schedule is available on the web at:

<https://secureapp.dhs.state.ia.us/MedicaidFeeSched/X30.xml>

For more information on services billable to IDPH and IME refer to the Child Health Service Summary document, it is available on the web at:

http://www.idph.state.ia.us/hpcdp/common/pdf/mch/child_summary_2011.pdf

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Appendix A22: Electronic Expenditure Workbook (EEW)

MCH EXPENDITURE REPORT
For the Month of:

Contractor:
Address:
Contract Number:
Contractor Vendor Code:
Contract Period:

MATERNAL HEALTH												
GRANT FUNDS					MATCHING FUNDS / PROGRAM INCOME							
Budget Category	BUDGETED	MONTHLY TOTAL	Spent Funds YTD	% of Total YTD	FFY 2017 Operating Capital Funds Received	Direct Service Title XIX	Third Party Payors	Employment	In-Kind	Other Funds	Matching Funds Monthly Total	Matching Funds YTD
A. Salaries/Fringe	0.00		0.00	#DIV/0!							0.00	0.00
B. Contracted Providers	0.00		0.00	#DIV/0!							0.00	0.00
C. Equipment	0.00		0.00	#DIV/0!							0.00	0.00
D. Other	0.00		0.00	#DIV/0!							0.00	0.00
E. Indirect/Admin	0.00		0.00	#DIV/0!							0.00	0.00
TOTAL	0.00	0.00	0.00	#DIV/0!		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Monthly Collections											0.00	0.00
Program Income Balance						0.00	0.00	0.00	0.00	0.00	0.00	0.00

CHILD HEALTH												
GRANT FUNDS					MATCHING FUNDS / PROGRAM INCOME							
Budget Category	BUDGETED	MONTHLY TOTAL	Spent Funds YTD	% of Total YTD	FFY 2017 Operating Capital Funds Received	Direct Service Title XIX	Third Party Payors	Employment	In-Kind	Other Funds	Matching Funds Monthly Total	Matching Funds YTD
A. Salaries/Fringe	0.00		0.00	#DIV/0!							0.00	0.00
B. Contracted Providers	0.00		0.00	#DIV/0!							0.00	0.00
C. Equipment	0.00		0.00	#DIV/0!							0.00	0.00
D. Other	0.00		0.00	#DIV/0!							0.00	0.00
E. Indirect/Admin	0.00		0.00	#DIV/0!							0.00	0.00
TOTAL	0.00	0.00	0.00	#DIV/0!		0.00	0.00	0.00	0.00	0.00	0.00	0.00
Monthly Collections											0.00	0.00
Program Income Balance						0.00	0.00	0.00	0.00	0.00	0.00	0.00

hwb-1 OCTOBER - JUNE				
GRANT FUNDS				
Budget Category	BUDGETED	MONTHLY TOTAL	Spent Funds YTD	% of Total YTD
A. Salaries/Fringe	0.00		0.00	#DIV/0!
B. Contracted Providers	0.00		0.00	#DIV/0!
C. Equipment	0.00		0.00	#DIV/0!
D. Other	0.00		0.00	#DIV/0!
E. Indirect/Admin				
TOTAL	0.00	0.00	0.00	#DIV/0!