Department of HUMAN SERVICES

ia health link

2021

MEDICAID REFERENCE GUIDE

Iowa Department of Human Services

Comm. 580 (Rev. 04/21)

Forward from the DHS Director

Nearly one in four Iowans rely on Iowa Medicaid for their health care.

Administering a program this significant takes a dedicated team committed to the DHS mission of helping Iowans achieve healthy, safe, stable and self-sufficient lives through the programs and services we provide.

The Iowa Medicaid team works tirelessly to make sure Iowans have access to quality health care and critical services. In this past year, this work has been more important than ever as we confront a global pandemic that has tested our system in every way. Our team has adapted and risen to the occasion to implement program flexibilities to ensure continued coverage for our members and to ease administrative burden on providers so they can focus on delivering care to Iowans. I am tremendously grateful for the team's hard work and dedication.

To better shine a light on the state's Medicaid program, the Iowans it serves, and the services it provides, the Department created this first edition of the Iowa Medicaid Reference Guide. There have been a number of changes to the program over the past several years at both the state and federal levels. We operate a variety of programs and waivers, with different eligibility criteria and different services. To put it simply, Medicaid is complicated and constantly evolving.

The Department created this resource for lawmakers and stakeholders to understand how the Medicaid program operates in Iowa. Our goal in creating this guide has been to strike the right balance of providing enough information to be educational and thorough, while being concise enough to be useful. We will update this reference guide annually before each legislative session as we move forward.

Thank you for taking your time to learn more about Iowa Medicaid and investing in the Iowans who rely on us.

Kelly Garcia

Kelly Garcia
Director, Iowa Department of Human Services

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Medicaid Eligibility and Services

At a Glance

HOW AND WHERE TO APPLY FOR MEDICAID

Uninsured and low-income individuals needing medical assistance can apply for Medicaid in several different ways:

- **Online** at https://dhsservices.iowa.gov/apspssp/ssp.portal or https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/.
- **In-person** at any local DHS office, federal qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided.
- **By mailing** a completed application to:
  - Imaging Center 4, PO Box 2027, Cedar Rapids, IA 52406.
- **By calling** 1-855-889-7985.
- **By emailing** or faxing a completed application to a local DHS office.

MEDICAID

- Age 65 or older, disabled, blind, families with dependent children, pregnant women, children (up to age 21), children formerly in foster care (up to age 26), adults ages 19-64, and individuals with breast and/or cervical cancer.
- Eligibility is based on financial and non-financial criteria, such as income, assets, citizenship, Iowa residency, immigration status, disability when used as a basis for eligibility.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

- Age 55 or older; Live in select Iowa counties; Be certified by state as eligible for nursing home care; Live in the community (not a nursing home); Be able to live safely in the community; Agree to receive health services exclusively through the PACE organization

IHAWP (Iowa Health and Wellness Plan)

- Individuals ages 19-64
- Same eligibility non-financial requirements as Medicaid; Income at or below 133% Federal Poverty Level (FPL); Not eligible for Medicaid under the mandatory coverage groups; Not entitled to or enrolled in Medicare Part A or Part B
- There are no charges for health services during a member's first year of enrollment. Beginning in the member's second year of enrollment, small monthly contributions may be required, depending on completion of Healthy Behaviors and family income.

DWP (Dental Wellness Plan)

- Adults age 19 and older
- Coverage is not available for: PACE, Health Insurance Premium Payment (HIPP), Presumptive Eligibility (PE), Persons Eligible only for the Medicare Savings Program (MSP), Medically Needy (MN), Periods of retroactive eligibility, Nonqualified immigrants receiving time-limited coverage for certain emergency medical
- $3/month for members above 50% of FPL; Can be waived if Healthy Behaviors are met

HAWKI (Healthy and Well Kids in Iowa)

- Children under ages 0-18
- Income at or below 302% FPL for both Hawki and Hawki Dental Only
- Premiums are based on family income. No family pays more than $40/month. Some families pay nothing at all.

FPP (Family Planning Program)

- Limited coverage for family planning-related services for individuals ages 12 -54
- Income at or below 300% FPL; Resident of Iowa, U.S. citizen or qualified non-citizen capable of bearing or fathering children; Not currently receiving Medicaid or IHAWP

ELIGIBILITY OVERVIEW

Medicaid is a health insurance program for certain groups of people based on both financial and non-financial criteria. When applying for Medicaid, DHS requires proof of all eligibility factors except residency, household size and pregnancy. However, if any are questionable, DHS will request verification through electronic data sources or through a request for information from the applicant. In addition to meeting certain income levels, applicants need to meet specific eligibility requirements before they can be considered for Medicaid. Below are some general requirements. More detailed eligibility requirements, by population or coverage, follow.

- **A child under the age of 21**
- **A parent living with a child under the age of 18**
- **A woman who is pregnant**
- **A child in foster care or subsidized adoption (up to age 21)**
- **A child formerly in foster care**
- **A woman in need of treatment for breast or cervical cancer**
- **A person who is elderly (age 65 or older)**
- **A person who is disabled according to Social Security standards**
- **An adult between the ages of 19 and 64 and whose income is at or below 133 percent of the Federal Poverty Level (FPL)**
- **A person who is blind or disabled**
- **A person who is a resident of Iowa and a U.S. citizen**
- Others may qualify

Once approved for Medicaid, a majority of individuals are automatically enrolled with a Managed Care Organization (MCO), unless they qualify for a Fee-for-Service (FFS) program. The date of the individual's MCO enrollment is the same as the effective date of eligibility.

Though DHS certifies eligibility for a full year, any change in household circumstances must be reported and can affect an individual's eligibility for Medicaid. Before benefits are canceled or reduced, the member is given a notice of at least 10 days prior as required by federal law.

Supplemental Security Income (SSI) Recipients

SSI is a federal cash assistance program administered by the Social Security Administration (SSA). Individuals are eligible for SSI if they have limited income and resources and are age 65 or over, blind, or disabled. SSA sets the financial eligibility criteria and determines individual eligibility. SSI beneficiaries are automatically eligible to receive Medicaid in Iowa.

Medicaid for Employed Persons with Disabilities (MEPD)

MEPD is available to individuals who meet the following eligibility criteria:

- Under the age of 65
- Determined disabled based on Social Security Administration medical criteria for disability
- Have earned income from employment or self-employment
- Not eligible for other Medicaid coverage groups other than Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, or Medically Needy
- Meets general Supplemental Security Income-related Medicaid eligibility requirements

Individuals enrolled in MEPD must pay a monthly premium.

ELIGIBILITY BY POPULATION

Women

Medicaid offers special aid to women in Iowa who are pregnant. Applicants must meet certain age, financial, and/or other non-financial requirements to qualify and received these services.

MEDICAID FOR PREGNANT WOMEN

Pregnant women qualify for Medicaid benefits in Iowa with a household income limit of 375 percent of the Federal Poverty Level (FPL). Self-attestation of pregnancy is accepted by the Department. Once a pregnant woman is determined Medicaid eligible, she remains eligible regardless of any change in her circumstance for the duration of the pregnancy plus 60 days post-partum.

Medically Needy

Medically Needy, or the spenddown program, is available to parents or caretakers, children under age 18, and SSI-related individuals, whose income is too high for Medicaid, but their medical costs are so high that it uses up most of their income. Those who qualify for Medically Needy are responsible for paying some of the costs of their medical expenses. Eligibility requirements include:

- Must be a parent/caretaker of a child under the age of 18 (or 18 and expected to graduate from high school prior to turning 19) residing in the home; or
- Children under 18 (or 18 and expected to graduate from high school prior to turning 19) if the family income is over the income limit for traditional Medicaid.
- Must be age 65 or older to be eligible as an aged person, must meet the SSI or social security criteria for blindness to be eligible due to blindness, or must meet SSI or social security criteria for disability to be eligible due to disability; and
- Resources do not exceed $10,000

Medicaid eligibility is granted when spenddown is met. Spenddown is the process in which a Medically Needy person's excess income is obligated for allowable medical expenses in order to reduce countable income to the household's medically needy income level.

Children and Youth

Generally, to qualify for children's benefits, the child must be age 18 or younger; however, eligibility qualifications based on age vary by program.

FORMER FOSTER CARE YOUTH

Upon aging out of foster care, the state places young adults into one of two Medicaid eligibility groups: Medicaid for Independent Young Adults (MIYA) or Expanded Medicaid for Independent Young Adults (E-MIYA).

Medicaid for Independent Young Adults (MIYA)
Created in 2006, MIYA is a specific Medicaid coverage group for young adults who have aged out of foster care. MIYA eligibility can be established for any youth who left foster care on or after May 1, 2006, and meet the following requirements:

- The youth resided in foster care and the state was responsible for the youth's placement and care when they turned age 18.
- The youth left foster care on or after May 2006.
- The youth is 18 years old, but under age 21.
- The youth's income is under 254% FPL.
- They are not a required Medicaid household member of a spouse or child's eligibility group.

Expanded Medicaid for Independent Young Adults (E-MIYA)
E-MIYA was created in 2014. This eligibility group allows former foster youth to receive Medicaid benefits until they reach the age of 26. There is no financial test to be eligible. The eligibility requirements include:

- A young adult between ages 18 and 26 who is not eligible for other Medicaid coverage.
- Was in foster care under the responsibility of the state on the date of attaining 18 years of age.
- Was enrolled in the Iowa Medicaid program in a coverage group that is funded under Title XIX of the Social Security Act while in foster care.

CHILDREN'S MEDICAID

To be eligible for these coverage groups, the individual must be under age 19 and have a gross income under 167% of the FPL. Babies are eligible regardless of income.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)/HEALTHY AND WELL KIDS IN IOWA (HAWKI)

CHIP covers children under the age of 19 in working families who have too much income to qualify for Medicaid, but cannot afford private health insurance. In Iowa, CHIP is offered through Hawki. Some households may be required to pay a monthly premium based on family income. No family pays more than $40 a month. Some families pay nothing at all. Eligibility ends on the first day of the month following the month of the youth's 19th birthday.

Children and Adults with Disabilities

MEDICAID FOR KIDS WITH SPECIAL NEEDS (MKSN)

MKSN is a program that helps pay medical bills for children with special needs due to a disability. To qualify, the child must:

- Be under the age of 19
- Have a disability, per the standards of the Social Security Administration (SSA)
- Have family income no more than 300% FPL
- Be a U.S. citizen

HOME- AND COMMUNITY-BASED SERVICE (HCBS) WAIVERS

HCBS waivers are for people with disabilities and older Iowans who need services to allow them to maintain a good quality of life and stay in their home and community instead of going to a long-term care facility. Individuals must be eligible for Medicaid and meet the requirements of the HCBS program they are applying for and/or receiving. Applicants must also be certified as being in need of nursing facility level care, skilled nursing facility level care, hospital level care, or being in need of intermediate care or an intermediate care facility for the intellectually disabled. HCBS waivers provide a variety of services in members' homes that are not available through traditional Medicaid. There are 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)
- Children who have a serious mental, behavioral, or emotional disorder (CMH)
- People who are elderly (EW)
- People who are ill or handicapped (HD)
- People who have an intellectual disability (ID)
- People who have a physical disability (PD)

In addition to income, resource, and standard non-financial eligibility criteria shared across

Medicaid coverage groups, the following are eligibility criteria for the HCBS waivers:

- Age, disability, or medical need
- Level of institutional care need
- Need for waiver services
- A determination by Department staff that the cost of the waiver program does not exceed the established cost limit for the person's level of care

HABILITATION SERVICES

Habilitation services have the same eligibility requirements as the HCBS waivers. The applicant must experience functional limitations typically associated with chronic mental illness.

STATE SUPPLEMENTARY ASSISTANCE

Eligibility for this coverage group is based on Supplemental Security Income (SSI) standards. The program supplements the income of aged, blind, disabled persons who receive federal Supplemental Security Income or would be eligible for SSI except their income exceeds the SSI limits. The following are the types of State Supplementary Assistance Iowa provides:

- Blind supplement
- Dependent person supplement
- Family-life home care supplement
- Mandatory state supplement
- Residential care supplement
- Supplement for Medicare and Medicaid eligible
- In-Home Health-Related Care

Adults Over Age 65

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY

For adults age 55 and over, Program of All Inclusive Care for the Elderly (PACE) is a program that blends Medicaid and Medicare funding. The PACE program must provide all Medicare and Iowa Medicaid covered services, as well as other services that will improve and maintain the member's overall health status. The program allows enrolled Medicaid members to stay healthy and live in the community as long as possible. Those interested in applying for the PACE program must contact a PACE enrollment coordinator and go through the application process. To qualify for this coverage group, an individual must:

- Be eligible for a Medicaid coverage group.
- Be age 55 or older.
- Live in a PACE-designated county: Boone, Cherokee, Dallas, Harrison, Jasper, Marshall, Madison, Marion, Mills, Monona, Plymouth, Polk, Pottawattamie, Story, Warren, and Woodbury counties. Have chronic illnesses or disabilities that require a level of care equal to nursing facility services.

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- Have chronic illnesses or disabilities that require a level of care equal to nursing facility services.
- Be certified by the state as eligible for nursing home care.
- Be able to live safely in their homes and community with help from PACE services.

MEDICARE SAVINGS PROGRAMS

The purpose of the Medicare Savings Programs is to assist low-income individuals with the payments of Medicare premiums, coinsurance, and deductibles. There are three Medicare Savings Programs offered in Iowa.

Qualified Medicare Beneficiary Coverage (QMB)
An individual is eligible for the QMB Medicaid Savings Program if they:

- Are entitled to Medicare Part A;
- Has net countable income that does not exceed 100% of the FPL by family size;
- Has resources that do not exceed twice the maximum allowed by the SSI program; and
- Meet all other SSI-related Medicaid non-financial eligibility requirements except for disability determination and age.

Specified Low-Income Medicare Beneficiary (SLMB)
SLMB has the same eligibility criteria as QMB, except the income requirement. Individuals eligible for SLMB have net countable monthly income that exceeds 100% of the FPL for the family size, but is less than 120% FPL. Medicaid will only pay the cost of Medicare Part B premiums for these specified low-income Medicare beneficiaries. Medicare copayments, deductibles, and Part A are not covered for this coverage group.

Expanded-Specified Low-Income Medicare Beneficiary (E-SLMB).
E-SLMB has the same eligibility criteria as SLMB, except the income requirement. Individuals eligible for E-SLMB have net countable monthly income that exceeds 120% of the FPL for the family size, but is less than 134% FPL. Medicaid will only pay the cost of Medicare Part B premiums for these expanded specified low-income Medicare beneficiaries. Medicare copayments, deductibles, and Part A are not covered for this coverage group.

Adults

BREAST AND CERVICAL CANCER TREATMENT

Men and women in Iowa qualify for Medicaid benefits under this aid type if they are younger than 65 years old and have been determined by the Breast and Cervical Cancer Early Detection Program (BCCEDP) to be in need of treatment for cancerous or precancerous condition of the breast or cervix. Applicants must also meet income guidelines (250% FPL) and not have credible health insurance coverage, have exhausted their lifetime benefits for breast or cervical cancer treatment, or have an exclusion clause in their health insurance for breast or cervical cancer treatment.

PARENTS/CARETAKERS

To be eligible for Family Medical Assistance Program (FMAP) coverage, an individual must be the parent or caretaker of a child under the age of 18, or age 18 and expected to graduate from high school prior to turning 19 years old, residing in the home. The income is a dollar amount, not FPL. Individuals receiving this coverage whose earned income exceeds the income limits may be eligible for transitional Medicaid to provide up to an additional 12 months of coverage.

IOWA HEALTH AND WELLNESS PLAN (IHAWP)

To be eligible for IHAWP, the applicant must:

- Be an adult age 19 to 64
- Have an income that does not exceed 133% FPL
- Live in Iowa and be a U.S. citizen or qualified alien
- Not be otherwise eligible for Medicaid or Medicare
- Not be pregnant

IOWA FAMILY PLANNING PROGRAM (FPP)

Iowa's FPP helps with the cost of family planning-related services. The program is available to individuals ages 12 through 54 who are not receiving Medicaid or Hawki benefits and whose income does not exceed 300% FPL. Additionally, postpartum women who were receiving Medicaid when their pregnancy ended and are not currently pregnant may qualify for FPP.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP)

The HIPP program is available to individuals who receive Medicaid and are enrolled in a major medical comprehensive insurance plan. When it is determined a plan is cost-effective to the State, the HIPP program assists the policyholder for a plan that pays primary by reimbursing the cost of premiums, coinsurance, copayments, and deductibles for the Medicaid-eligible individuals in their household. Cost-effective means a determination has been made that a savings will accrue to the State by paying the insurance premium, cost sharing, wrap benefits, and administrative cost because this is less than the cost to pay to cover the Medicaid-eligible individuals under a MCO.

Special Circumstances

PRESUMPTIVE ELIGIBILITY (PE)

PE provides Medicaid for a limited time while a formal Medicaid eligibility determination is being made by DHS. The goal of the PE process is to offer immediate health care coverage to people likely to be Medicaid eligible, before there has been a full Medicaid determination. PE is based on a household's statements regarding their circumstances and income. A qualified entity* enters the applicant's information into the Medicaid Presumptive Eligibility Portal to determine if the applicant qualifies. If determined to be eligible, the applicant will have temporary Medicaid eligibility during the PE period.

Individuals who may be eligible for PE include:

- Children under 19
- Pregnant women
- Parents and caretakers of children under 19
- Adults age 19-64
- Former foster care children under age 26
- Women screened and diagnosed through BCCEDP and needing treatment for breast or cervical cancer

*A qualified entity is generally defined as an enrolled Iowa Medicaid provider who is certified by DHS and is authorized to make PE determinations.

INCARCERATED INDIVIDUALS

Incarcerated individuals are eligible for Medicaid only when they are admitted to a non-correctional facility medical institution, such as a hospital. Payment is limited to inpatient hospital services only.

QUALIFIED ALIENS AND NON-CITIZENS

People who are not citizens or nationals of the United States may also be eligible for Medicaid in Iowa. If the person meets the eligibility requirements, non-citizen eligibility is based on whether the person is "qualified" (...to live permanently or indefinitely in the United States) or "non-qualified" (having not met the legal conditions for permanent residence). The table below shows the categories of individuals who are included in this special circumstance.

Legal Permanent Residents (LPRs)
Any person not a citizen of the U.S. who is residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
Also known as "Permanent Resident Alien," "Resident Alien Permit Holder," and "Green Card Holder" (includes Amerasians)

Aliens paroled into the U.S. for at least one year

Battered alien and children and parents of the battered alien

Members of federally recognized Indian tribes with cross-border treaty rights

Refugees (including Asylees, persons whose deportations are being withheld, Cuban/Haitian entrants, Iraqi/Afghani special immigrants, Amerasians)

COFA Adults Adults from the Compacts of Free Association (COFA) States of the Republic of Palau, the Republic of the Marshall Islands, and the Federated State of Micronesia.

Aliens granted conditional entry

Victims of human trafficking

Children under age 21 who are lawfully residing (as defined by the Children's Health Insurance Program Reauthorization Act of 2009) in the U.S.

WAITING PERIODS

No Waiting Period for Eligibility	Five-Year Waiting Period for Eligibility
Veterans and active duty members of the U.S. armed forces, including their spouses and dependent children	Lawful Permanent Residents, parolees, and battered aliens aged 21 or over **
Canadian born American Indians	
Lawful Permanent Residents who entered the U.S. on or before August 22, 1996	
Refugees (including Asylees, persons whose deportations are being withheld, Cuban/Haitian Entrants, Iraqi/Afghani special immigrants, and Amerasians)	
Members of federally recognized Indian tribes with cross-border treaty rights	
Lawful Permanent Residents and "lawfully residing" children under age 21 (includes parolees and battered aliens)	
Victims of trafficking*	
Compacts of Free Association (COFA) States of the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia	

Victims of Human Trafficking
The U.S. Department of Health and Human Services' Office of Refugee Resettlement (ORR) certifies individuals who meet the victims of severe human trafficking requirements.
These individuals meet the alien status criteria to be potentially eligible for benefits without a five-year waiting period during the period certified by ORR, or if they adjust to another acceptable alien status.
***** Exception to the five-year waiting period:***
An exception to the five-year waiting period is given to aliens in these categories who entered the U.S. before August 22, 1996, and remained continuously present in the U.S. since at least August 21, 1996

EMERGENCY MEDICAID

Nonimmigrants, undocumented aliens, and LPR adults still in their five-year waiting period may qualify for Emergency Medicaid coverage if all other eligibility requirements are met except for alien status. Undocumented aliens are not required to provide an SSN. If determined eligible, the individual is covered by Medicaid only while treatment is needed for an emergency medical condition, as verified by a medical provider.

CHILDREN ELIGIBLE BASED ON CHIP REAUTHORIZATION 2009

A determination of Medicaid eligibility is made by Express Lane, an expedited application process, at the time of either Food Assistance application or Food Assistance review is used to determine when a child meets initial eligibility requirements from the Mothers and Children (MAC) coverage group. A child will be eligible under MAC without filing a separate application when the child meets the following criteria:

- The child is under the age of 19.
- The child is eligible for Food Assistance.

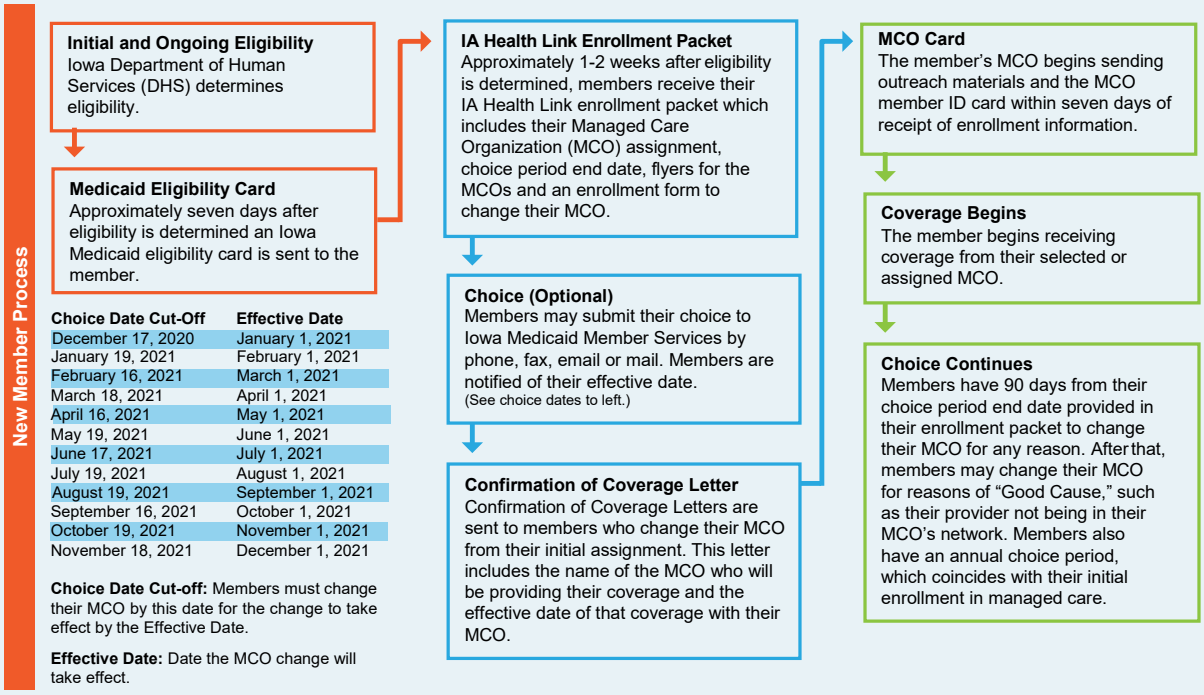
(Continued)

- The child fulfills Food Assistance requirements of attestation and verification of qualified alien or citizen status.
- A household member requests the child's Medicaid enrollment within 30 calendar days of issuance of Express-Lane Eligibility form 470-4851 Express Lane Medicaid for Children.

At a Glance

From Eligibility to Services

This flow chart shows what happens once an individual's application for Medicaid is approved and they are enrolled in the IA Health Link managed care program.



SERVICES BY POPULATION

Women

IOWA FAMILY PLANNING PROGRAM (FPP)

The Family Planning Program (FPP) is for men and women who are 12-54 years of age. The FPP helps with the cost of family planning related services. The FPP is a state-funded DHS program which replaced the Iowa Family Planning Network (IFPN) program.

This program allows men and women to get family planning services only. This program is a form of limited insurance coverage. If you are able to enroll in the FPP, most of your basic family planning services will be paid for. However, it does not meet the Affordable Care Act requirements for a minimum essential benefits plan.

What is the purpose of the FPP?

- Increase the spacing between births
- Improve future birth outcomes
- Reduce the number of unintended pregnancies and birth paid by Medicaid

What services are covered?

- Birth Control Exams
- Birth Control Counseling
- Limited Testing and Treatment for Sexually Transmitted Diseases (STDs)
- Pelvic Exams
- Pap Tests
- Pregnancy Tests
- Birth Control Supplies
- Voluntary Sterilization
- Emergency Contraception
- Ultrasounds (if medically necessary and related to birth control services)
- Yeast Infection Treatment

What types of birth control are covered?

- Birth Control Implants
- Intrauterine Devices (IUDs)
- Birth Control Pills
- Depo Provera Shots
- Sterilizations
- Vasectomies
- Diaphragms, Cervical Caps, Vaginal Rings
- Condoms
- Spermicidal Suppositories
- Birth Control Foam/ Jelly/Sponges
- Basal Thermometer

BREAST AND CERVICAL CANCER TREATMENT PROGRAM SERVICES

Medicaid covers needed breast and cervical cancer treatment for women diagnosed with a cancerous or precancerous condition of the breast or cervix who do not have health insurance coverage and are not eligible for Medicaid under one of the coverage groups. The woman must have been screened and diagnosed through the Breast and Cervical Cancer Early Detection Program or through use of Susan G. Komen Foundation funds and needs treatment for cancerous or precancerous conditions of the breast or cervix.

Children and Youth

HAWKI

Summary of Core Benefits

- Doctor visits
- Primary Care Provider (PCP)
- Specialists
- Immunizations (shots)
- Check-ups
- Hospital care
- Surgery
- Emergencies
- Non-emergency use of the ER
- Out-of-network coverage
- Eye exams
- Eye glasses & contact lenses
- Prescriptions
- Mental health services
- Substance use disorder

Some Additional Benefits

- Healthy Families Program
- Boys and Girls Club Membership
- Focus on Fitness Program
- TeleHealth Services and TeleMonitoring Program
- Health Wellness and Education Programs

Dental Benefits

- Dental exams
- X-rays
- Cleanings
- Fluoride
- Fillings for cavities
- Extractions
- Root canals
- Crowns
- Medically necessary orthodontics

Children and Adults with Disabilities

LONG TERM SERVICES AND SUPPORTS

Waiver Services

Health and Disability Waiver

The Medicaid Home- and Community-Based Services Health and Disability Waiver (HCBS HD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. HCBS HD waiver services are individualized to meet the needs of each member. However, decisions regarding what services are appropriate, the number of units or the dollar amounts of the appropriate services is based on the member's needs as determined by the member and an interdisciplinary team. Available services include:

- Adult day care
- Consumer-Directed Attendant Care (CDAC)
- Counseling services
- Home and vehicle modification
- Home delivered meals
- Home Health Aide Services (HHA)
- Homemaker services
- IMMT
- Nursing
- Nutritional counseling
- Personal Emergency Response System (PERS)
- Respite
- Consumer Choices Option (CCO)

AIDS/HIV Waiver

The Medicaid HCBS Acquired Immunodeficiency Syndrome/ Human Immunodeficiency Virus Waiver (HCBS AIDS/HIV) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. AIDS/HIV services are individualized to meet the needs of each member. The following services are available:

- Adult day care
- CDAC
- Counseling services
- Home delivered meals
- HHA
- Homemaker services
- Nursing care
- Respite
- CCO

Elderly Waiver

The Medicaid HCBS Elderly Waiver (HCBS EW) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. The following services are available:

- Adult day care
- Assisted living service
- Assistive devices
- Case management
- Chore
- CDAC
- Emergency response system
- Home and vehicle modification
- Home delivered meals
- HHA
- Homemaker
- Mental health outreach
- Nursing care
- Nutritional counseling
- Respite
- Senior companions
- Transportation
- CCO

Intellectual Disability Waiver

The Medicaid HCBS Intellectual Disability Waiver (HCBS ID) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. The following services are available:

- Adult day care
- CDAC
- Day habilitation
- Home and vehicle modifications
- HHA
- IMMT
- Nursing
- PERS
- Prevocational
- Respite
- Supported community living
- Supported community living – residential based
- Supported employment
- Transportation
- CCO

Brain Injury Waiver

The Medicaid HCBS Brain Injury Waiver (HCBS BI) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. The following

services are available:

- Adult day care
- Behavioral programming
- Career exploration
- Case management
- Consumer-directed attendant care
- Family counseling and training
- Home and vehicle modifications
- IMMT
- PERS
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living
- Supported employment
- Transportation
- CCO

Physical Disability Waiver

The Medicaid HCBS Physical Disability Waiver (HCBS PD) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. The following services are available:

- Consumer-directed attendant care
- Home and vehicle modifications
- PERS
- Specialized medical equipment
- Transportation
- CCO

Children's Mental Health Waiver

The intent of the Medicaid HCBS Children's Mental Health Waiver (HCBS CMH) is to identify services and supports that are not available through other mental health programs and services that can be used in conjunction with traditional services to develop a comprehensive support system for children with serious emotional disturbance. These services will allow children in this targeted population to remain in their own homes and communities. The following services are available:

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

Medicaid for Employed People with Disabilities

Medicaid for Employed People with Disabilities (MEPD) is a Medicaid coverage group to allow persons with disabilities to work and continue to have access to medical assistance. This program provides health coverage through a Managed Care Organization (MCO) chosen by the member. MEPD members receive the full package of benefits from the IA Health Link program. Prescription services are included for members who do not have Medicare. For those members enrolled with Medicare as well as MEPD, prescription coverage is provided through a Medicare Part D plan. MEPD pays for members' Medicare Premiums.

Program of All Inclusive Care for the Elderly Services

Program of All Inclusive Care for the Elderly Services (PACE) services include, but are not limited to, all Medicare and Medicaid services. A PACE center is facility where the PACE organization is housed and provides medical services to support and assist you. The PACE center has a medical clinic that includes physician and nursing services. Some of the other services and supports available with prior approval are physical therapy, occupational therapy, speech therapy, personal care, nutritional counseling, recreational therapy, social activities and meals.

Other medically necessary services that cannot be provided at the PACE center or in your home, will be coordinated for you. PACE staff will schedule appointments for you and schedule transportation to your appointments, if needed. Any services not available at the PACE center must be authorized by the PACE team of professionals.

Appointments for medical care outside of the PACE center are required to have prior authorization by the PACE team. You will need to pay for unauthorized appointments and services. If approved, the services listed below can be provided, but are not limited to the following:

- Meals
- Nutritional counseling
- Personal care services
- Physical therapy, occupational therapy, and other restorative therapies
- Primary medical care (including physician and nursing services)
- Recreational therapy and social activities
- Social work services
- Transportation
- Prescription drugs

Other PACE Benefits

- Ambulance services
- Audiology services
- Dental services
- Home health services
- Hospice services
- Inpatient hospital services
- Laboratory and X-ray services
- Medical equipment and supplies
- Nursing facility services
- Optometric services
- Outpatient hospital services
- Palliative care services
- Podiatry services

Behavioral Health Services

BEHAVIORAL HEALTH INTERVENTION SERVICES (BHIS)

BHIS are supportive, directive, and teach interventions provided in a community-based or residential group care environment designed to improve the individual's level of functioning (child and adult) as it relates to a mental health diagnosis, with a primary goal of assisting the individual and his or her family to learn age-appropriate skills to manage their behavior, and regain, or retain self-control. Specific services available through the BHIS include individual, group, and family skill building services, crisis intervention services, and services to children in residential settings. BHIS services are typically provided in the home, school, and community, as well as foster family and group care settings. Members eligible for full menu of state plan benefits may access BHIS.

APPLIED BEHAVIOR ANALYSIS (ABA)

ABA treatment is available to members with a diagnosis of Autism Spectrum Disorder. ABA services are individualized treatment services that focus on increasing positive behaviors and decreasing negative or interfering behaviors to improve a variety of well-defined skills. ABA services are highly structured and include incidental teaching, intentional environmental modifications, and reinforcement techniques to produce socially significant improvement in human behavior. ABA strategies include reinforcement, shaping, chaining of behaviors, and other behavioral strategies to build specific targeted functional skills. Members eligible for full menu of state plan benefits may access ABA.

Adults

IOWA HEALTH AND WELLNESS PLAN

The Iowa Health and Wellness Plan provides comprehensive health coverage at low or no cost to Iowans between the ages of 19 and 64.

Membership in the Iowa Health and Wellness Plan include many benefits such as the ones outlined below:

Benefits:

- Doctor visits
- Women's health
- Prescription drugs
- Dental care
- Preventive health services (vaccinations, blood pressure, and cancer screenings)
- Hospitalizations
- Emergency services
- Mental health and substance use services

DENTAL WELLNESS PLAN

The Dental Wellness Plan provides dental coverage for adult Iowa Medicaid members age 19 and older. Dental Wellness Plan members have access to full dental benefits during the

first year. Members must complete 'Healthy Behaviors' each year to maintain full benefits in the next year.

Full benefits include:

- Diagnostic and Preventive Dental Services
  - Exams
  - Cleanings
  - X-rays
  - Fluoride
- Fillings for Cavities
- Surgical and Non-Surgical Gum Treatment
- Root Canals
- Dentures and Crowns
- Extractions

Healthy Behaviors

The **Healthy Behaviors Program** is a way for all **Iowa Health and Wellness Plan (IHAWP)** *(Iowa Wellness Plan)* and **Dental Wellness Plan** members to work with health care providers to be healthy and stay healthy. Participating in the Healthy Behaviors Program helps IHAWP members begin the conversation with providers and saves money.

IHAWP members who complete the Healthy Behaviors requirements will not be responsible for a monthly contribution. A contribution or premium is the amount of money members may have to pay each month to keep health coverage. During the first year of coverage there are no monthly contributions for any IHAWP members. After that, some members may be responsible for a monthly contribution if they decide not to complete the Healthy Behaviors requirements.

To participate in the Healthy Behaviors Program and avoid paying a monthly contribution after the first year of coverage Iowa Health and Wellness Plan members must:

1. **Get a wellness exam** (annual physical) from their health care provider or a dental exam from their dental provider; and
2. **Complete a health risk assessment** (HRA).

There are no costs for health services during the first year and limited costs after that based on completion of Healthy Behaviors.

Costs:

- No charges for office visits, prescription drugs, preventive services, mental health services, or hospitalization.
- Members could be required to pay $8 for using the emergency room when it is not an emergency.
- Some members in their second year of Iowa Health and Wellness Plan eligibility may be required to pay a small monthly contribution, or premium. The payment amount will be based on member income. Members can complete Healthy Behaviors and have the contributions waived for the next eligibility year.

Special Circumstances

INCARCERATED

Individuals who are incarcerated may be eligible for limited Medicaid coverage when they are admitted to a medical institution such as a hospital. Payment is limited to inpatient hospital services. An inmate released on probation or parole, even if living in a halfway house or residential facility, are not considered incarcerated and can get full Medicaid, if otherwise eligible.

QUALIFIED ALIENS AND NON-CITIZENS

Medicaid eligibility for aliens is based on whether the alien is a “qualified” or “nonqualified” alien and otherwise meets the Medicaid eligibility requirements. Medicaid benefits are available to pay for the cost of emergency services for an alien who does not meet Medicaid citizenship or alien requirements or social security number requirements. Emergency medical coverage is also available to otherwise eligible people whose alien status cannot immediately be determined with documentation from the United States Citizenship and Immigration Services (USCIS) or who do not claim to have a qualified alien status.

EMERGENCY MEDICAID

Medicaid is available to pay for the cost of emergency services for aliens who do not meet citizenship, alien status, or social security number requirements.

MEDICAID-ONLY SERVICES

HCBS Services Programs

Home- and Community-Based Services (HCBS) are Medicaid programs that provides members more choices about how and where they receive services. Home- and Community-Based Services are for people with disabilities and older Iowans who need services to allow them to stay in their home and community instead of going to an institution. There are several programs that provide home and community based services. The program names are HCBS Waivers (there are seven), Habilitation, PACE, Home Health, Hospice, and Targeted Case management.

COMMUNITY-BASED NEUROBEHAVIORAL REHABILITATION SERVICES (CNRS)

CNRS is a specialized category of neuro-rehabilitation provided by a multidisciplinary team of allied health and support staff that have been trained in, and deliver, services individually designed to address cognitive, medical, behavioral, and psychosocial challenges, as well as the physical manifestations of an acquired brain injury. The service is provided to adults with brain injury and co-occurring mental health diagnosis.

RESIDENTIAL CNRS

These services are available to those who currently reside in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspection and appeals. The intention of the service is to support the member increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize independence.

INTERMITTENT CNRS

These services are available to those who reside in their own home. The intention of the service is to support the member, and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

CONSUMER DIRECTED ATTENDANT CARE (CDAC)

In the HCBS waiver program, there is an opportunity for people to have help in their own homes. Consumer directed attendant care (CDAC) are services designed to help people do things that they normally would for themselves if they were able. CDAC is a direct, hands-on service which takes place in the home or community. People may reach a point where they need help to remain in their own home. This may happen because of an accident, a lengthy illness, disability, or aging problems. Fortunately, there is an option for people in this situation. A person may consider hiring a CDAC assistant.

CONSUMER CHOICES OPTION (CCO)

Consumer Choices Option (CCO) is an option available under the HCBS Waivers that gives you control over a targeted amount of Medicaid dollars so that you can develop a plan to meet your needs by directly hiring employees and/or purchasing other goods and

services. The CCO offers more choice, control and flexibility over the member's services as well as more responsibility.

Money Follows the Person

Money Follows the Person Partnership for Community Integration Project provides opportunities for individuals in Iowa to move out of an Intermediate Care Facility for Intellectually Disabilities and into their own homes in the community of their choice. Grant funds provide funding for the transition services and enhanced supports needed for the first year after they transition into the community.

Non-Emergency Medical Transportation (NEMT)

The NEMT services are for members with full Medicaid benefits, who need travel reimbursement or a ride to get to their medical appointments. Eligible members will receive NEMT services from different NEMT brokers depending on their eligibility status and whether they receive coverage directly from Iowa Medicaid Fee-for-Service or are enrolled in the IA Health Link managed care program. An NEMT broker is a contracted provider with the Iowa Department of Human Services (DHS), the Iowa Medicaid Enterprise (IME), and the IA Health Link Managed Care Organizations (MCOs) The broker checks member and trip eligibility, handles claims, and follows up on trips and claims. Hawki members are not eligible for NEMT.

Pre-Admission Screening and Resident Review (PASRR)

The goal of the PASRR process is to reduce inappropriate institutionalization for individuals with serious mental illness, intellectual disability and related conditions and improve the quality of life for those individuals who are placed in Medicaid certified facilities. PASRR process identifies people with mental illness and/or intellectual disability and ensures they are served appropriately.

Health Insurance Premium Payment Program (HIPP)

The HIPP program helps people get or keep health insurance through their employer by reimbursing the cost of the health insurance premium. HIPP helps by paying for the insurance premium.

Health Homes

The Health Home service delivery model authorized by the Affordable Care Act Section 2703 Amendment provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for Iowa Medicaid. This provision supports an approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care (without any harm whatsoever to individuals, families, or communities).

The Health Home Delivery model supports members with qualifying conditions with access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults. Health Homes provide whole-person care not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes.

SMDL #10-024 https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD10024.pdf

Iowa has two Health Home Programs.

CHRONIC CONDITION HEALTH HOME

Primary care providers enroll members that meet the following criteria:

One chronic condition and the risk of developing another:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Body Mass Index (BMI) over 25
- Chronic Pain
- COPD
- Hypertension
- BMI over 85th percentile for pediatric populations

INTEGRATED HEALTH HOME

Behavioral health providers enroll members that meet the following criteria;

- **Adults**
  - Severe Mental Illness (SMI) – diagnosable mental, behavioral, or emotional disorder identified in the DSM of mental disorders (SUD, Neurodevelopmental, ID not qualifying DX) with a severe functional impairment
- **Children**
  - SED – (ages 4-18) diagnosable mental, behavioral, or emotional disorder identified in the DSM of mental disorders (SUD, Neurodevelopmental, ID not qualifying DX) with a severed functional impairment.
  - For children three years or younger, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC: 03R) may be used as the diagnostic tool. For children four years and older, the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the most current DSM.
  - Members with approved Habilitation Services

INTEGRATED HEALTH HOME (CONT.)

- **Members with approved Habilitation Services**
- **Members with approved Childrens Mental Health Waiver**

Health Homes are required to provide the following Health Home Services to enrolled members

- **Comprehensive Care Management:** Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.
- **Care Coordination:** Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the Health Home.
- **Health Promotion:** Health Promotion means the education and engagement of an individual in making decisions that promotes health management, improved disease outcomes, disease prevention, safety and an overall healthy lifestyle.
- **Comprehensive Transitional Care:** Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community based group home, family, or self-care, another Health Home).
- **Individual and Family Support Services:** Individual and Family Support Services include communication with member, family and caregivers to maintain and promote the quality of life with particular focus on community living options. Support will be provided in culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
- **Referral to Community and Social Support Services:** Comprehensive transitional care is the facilitation of services for the individual and supports when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community based group home, family, or self-care, another Health Home).

IDPH PARTNERSHIP PROGRAMS

The following services are provided in collaboration with the Iowa Department of Public Health (IDPH):

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

EPSDT is a program for children to receive preventive health care services including oral health services. The program's purpose is to find and treat health problems before they become more serious. EPSDT is also known as the "Care for Kids" Program. It focuses on providing Medicaid eligible children age birth through 20 years with preventive health care services including physicals, immunizations, and vision, hearing and dental exams.

I-Smile

I-Smile is a statewide program that connects children and families with dental, medical, and community resources to ensure a lifetime of health and wellness. For more information on the I-Smile program visit ismile.iowa.idph.gov.

Medicaid for Kids with Special Needs (MKSN)

MKSN members receive coverage from the IA Health Link program. This program provides health coverage through a Managed Care Organization (MCO) chosen by the member.

Early ACCESS

Early ACCESS is Iowa's system for providing early intervention services. It is available to infants and toddlers from birth to age three years who have a:

- Health or physical condition affecting their growth and development, or
- Delays in their ability to play, think, hear, see, eat, talk, or move.

The first three years of a child's life are the most important when setting the foundation for ongoing development. Starting supports and services early improves a child's ability to develop and learn. The focus of Early ACCESS is to support parents to help their children learn and grow throughout their everyday activities and routines. This means Early ACCESS service providers work with parents and other caregivers to help their children develop to their fullest potential.

The Iowa Medicaid Enterprise (IME) along with the Iowa Department of Education, Iowa Department of Public Health, and the University of Iowa's Child Health Specialty Clinics are responsible for the state-level early intervention system.

Iowa's area education agencies (AEAs) are responsible for administration of Early ACCESS across the state to ensure that no matter where a family lives in Iowa, services will be available. Service coordination, assessments, evaluations, and any needed early intervention services provided by Early ACCESS are available at no cost to families.

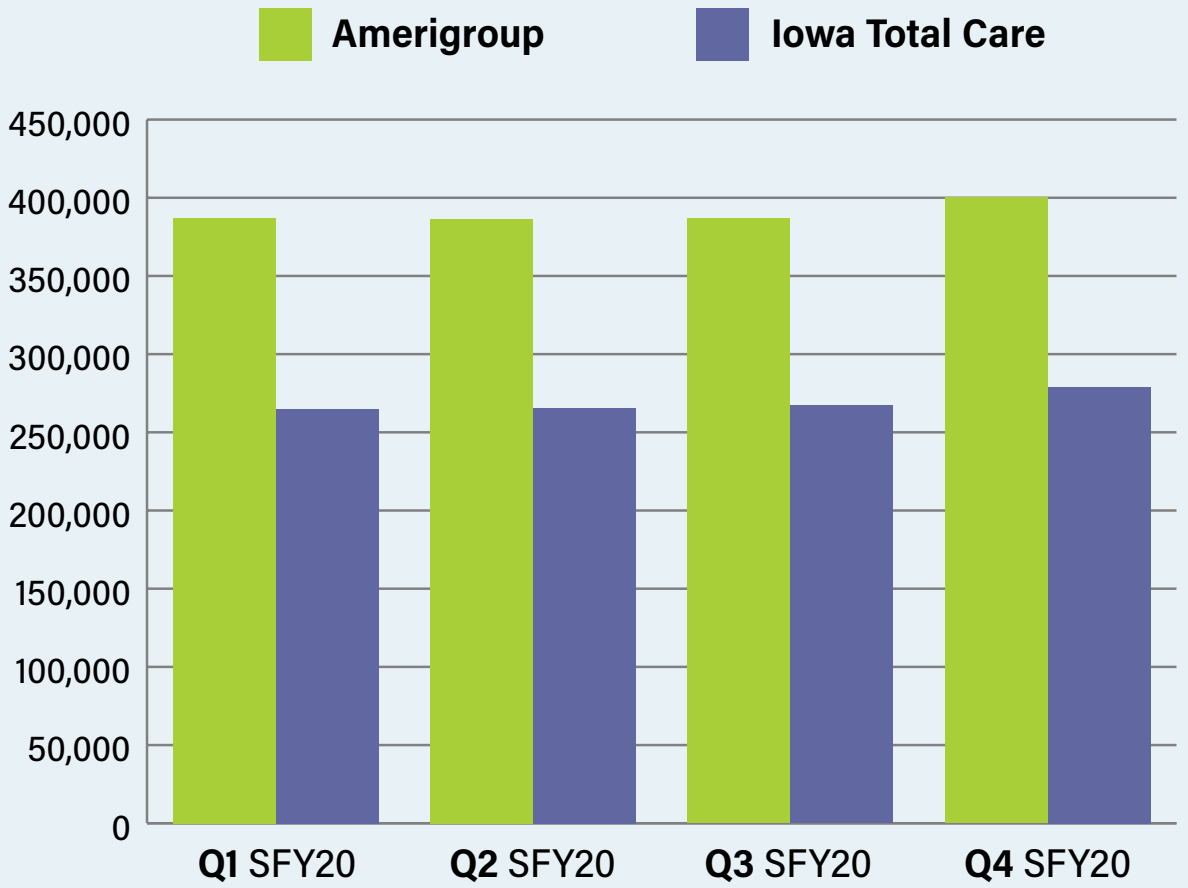
SUMMARY

Medicaid is a health insurance program for certain groups of people based on both financial and non-financial criteria. Individuals can apply for Medicaid coverage online, in person, by mail or email, or by phone call. Most people who are eligible receive a comprehensive medical benefit package at no cost. In addition, certain groups of people are eligible for tailored packages of services which expand or limit their coverage based on their circumstances. A majority of Medicaid recipients receive their coverage from a MCO, or health plan, they choose. A MCO provides medical benefits to its members through a network of health care providers.

Chapter 2:
How Does Iowa Medicaid Make Sure Iowans Get Good Care?

At a Glance

Quarterly Enrollment by Managed Care Organization



**Total Managed Care enrollment by MCO by quarter for State Fiscal Year 2020 (SFY20) – July 1, 2019 through June 30, 2020.*

Total enrollment includes children enrolled in the Hawki program, but does not include members that receive benefits through the Department's Fee-for-Service (FFS) program. In SFY20 there were 38,979 FFS members.

Due to the effects of COVID-19 in Iowa, disenrollment from Medicaid was suspended starting in March 2020. As a result, the total number of members enrolled increased in the second half of SFY20.

IA HEALTH LINK
IOWA'S MANAGED CARE SYSTEM

Background

Since 2016, Iowa has used a managed care approach to administer the majority of its Medicaid program. Managed care organizations (MCOs), or health plans, contract with DHS to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and long term services and supports. Today, DHS has contracts with two MCOs to administer the program: Amerigroup Iowa, Inc. and Iowa Total Care, Inc.

Under managed care, the Department pays a monthly capitation payment, similar to an insurance premium, to the MCOs for each member enrolled in the plan. The MCO then pays providers for the allowable services provided to Medicaid beneficiaries. By paying MCOs a fixed amount per member in advance, the MCOs are at financial risk if the cost of care exceeds this rate and thus, incentivizes them to provide value-based care.

The MCOs are responsible for providing all covered Medicaid benefit services a beneficiary may need, as medically necessary.

MEMBER CARE

Choice of a primary care provider (PCP)

Upon enrollment in a MCO, the Medicaid member must choose a primary care provider (PCP) within 10 calendar days. A member's PCP is their main doctor. They help coordinate all of the member's health needs. If a member does not choose a PCP, the MCO will assign one to the member.

The PCP must be in the MCO's network, but can be a physician specializing in family or general medicine, internal medicine, pediatrics, obstetrics or gynecology; an advanced registered nurse practitioner (ARNP); or a physician assistant under the supervision of a physician.

A member can change their PCP at any time. The member's PCP, the PCP's location and office telephone number, are all listed on their MCO ID card.

Members have unlimited visits to their PCP. There is no cost to a member to see their PCP. PCPs provide medical care, advice and information to a member about their health.

Members may also see a specialist. Specialists are covered by a MCO. Some specialists require a referral from the member's PCP.

A Medicaid member may also receive a second opinion from an in-network provider at no cost to them.

Access to Care

MCOs must ensure their members have access to Medicaid-covered services through their provider network on a timely basis. They are required to develop and maintain a network of providers to meet the needs of their members. MCOs also must maintain access to network

providers based on federal and state requirements. If an in-network provider is not available, the MCO is still required to locate a willing provider to ensure members have access to medically necessary and appropriate services.

MANAGED CARE OVERSIGHT

Performance monitoring and data analysis are critical components in assessing how well the MCOs are maintaining and improving the quality of care delivered to members. The Department deploys multiple oversight tools in this effort including quarterly and annual performance reports. These reports are posted to the DHS website: https://dhs.iowa.gov/ime/about/performance-data

CONTRACT MANAGEMENT

Annual Evaluation

The relationship between the MCOs and the Department is established through contracts, beginning with procurement though a competitive bidding process. The contract is the mechanism by which MCOs are held responsible for addressing quality of care at both the programmatic and individual provider level. They contain several requirements based on quality initiatives and measurements.

The Department annually evaluates the IA Health Link program through an external quality review and evaluation of national performance measures. Plans receive financial incentives for exceeding performance standards in key areas described in the contract. This is referred to as “pay for performance.” All MCO contracts are posted to the DHS Website:

https://dhs.iowa.gov/MED-16-009_Bidders-Library

REVIEW OF NATIONAL PERFORMANCE MEASURES

Health Effectiveness Data and Information Set (HEDIS) measures
HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. HEDIS measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
The MCOs conduct the CAHPS survey, which is a national instrument for measuring consumer perception of issues such as access to services, quality of services, perceived difficulty accessing primary care, and difficulty accessing specialist care.

EXTERNAL QUALITY REVIEW (EQR)

An EQR of the MCOs is conducted annually related to quality outcomes, timeliness of services, and access to the services covered under each contract. The Department contracts with an external quality review organization (EQRO), Health Services Advisory Group (HSAG), to review measures, including, but not limited to:

- Availability of services
- Credentialing and re-credentialing of providers

- Confidentiality and security
- Medical records content/retention
- Member education/prevention programs
- Coverage and authorization of services
- Cultural competency
- Enrollment/disenrollment timeliness
- Grievances and appeals
- Coordination and continuation of care
- Contract evaluation
- Encounter data
- Quality assurance plan

EQR reports are posted on the DHS website:

https://dhs.iowa.gov/ime/about/performance-data/annualreports

MCO Quarterly Performance Reports

In compliance with state and federal regulations, the MCOs submit quality improvement data to the Department on a monthly, quarterly, bi-annual and annual basis. These reports include documentation of MCO management of specific populations, consumer supports, and program operations. The reports, with a number of elements required through oversight legislation, are comprehensive and focus on compliance areas, as well as health outcomes over time. The Department examines the data from a compliance perspective and conducts further analysis if any issues are identified. While there are specific performance standards in the contract for a limited set of items, not all data reported is directly linked to a contractual requirement. Items which do have contractual requirements are indicated in the reports.

Monthly demographic and quarterly performance reports are posted to the DHS website:

https://dhs.iowa.gov/ime/about/performance-data

MCO Advisory Councils

There are a number of advisory groups that provide oversight of the Department's management of the state's Medicaid program. The Department regularly meets with each advisory group listed below. Meeting agendas and minutes for each respective group can be found on the DHS website.

COUNCIL ON HUMAN SERVICES

The Council on Human Services advises on matters within the jurisdiction of all of DHS and provides recommendations to the Governor. The Council meets monthly.

MEDICAL ASSISTANCE ADVISORY COUNCIL (MAAC)

The MAAC advises the Medicaid Director about health and medical care services under the Medicaid program. The MAAC is mandated by federal law and further established in Iowa Code. They meet quarterly. The results of CAHPS are shared with the MAAC.

HAWKI BOARD

The Hawki Board provides direction to the Department on the development, implementation, and ongoing administration of the Hawki program. The Hawki Board meets six times a year.

PHARMACEUTICAL AND THERAPEUTICS (P&T)

The P&T Committee is charged by law with developing and providing ongoing review of the Preferred Drug List (PDL). The PDL is a list of drugs approved by the Department to be prescribed for Medicaid members. Drugs not on the PDL may not be covered by Medicaid.

CLINICAL ADVISORY COMMITTEE (CAC)

The purpose of the CAC is to increase the efficiency, quality, and effectiveness of the Medicaid healthcare system. The CAC provides a process for physician/provider intervention to promote quality care, member safety, cost effectiveness, and positive physician/provider relations through discussion about Medicaid benefits and health care services.

DRUG UTILIZATION REVIEW (DUR)

Centers for Medicare and Medicaid Services (CMS) requires state Medicaid programs to have a DUR program consisting of prospective DUR, retrospective DUR, and an educational program. In Iowa, the DUR Board is referred to as the Iowa Medicaid DUR Commission. The Iowa DUR Commission is comprised of four Iowa Licensed physicians and four Iowa Licensed pharmacists who serve up to two, four-year terms, as well as a representative from the Department and a representative from one MCO.

STAKEHOLDER WORKGROUPS (VARIOUS)

The Department may at times create and conduct workgroups with stakeholders to review and gather feedback for improving Medicaid programs and processes.

MCO Provider Network Standards

MCOs are required to maintain a provider network which offers members a choice of providers. The MCOs ensure members have the right to select the provider of their choice without regard to differences in reimbursement rates. If a member enrolls with a MCO and is already established with a provider who is not a part of that MCOs network, the MCO shall make every effort to arrange for the member to continue with the same provider if the member so desires. In this case, the provider would be requested to meet the same qualifications as other providers in the network.

The MCOs are contractually obligated to maintain time and distance standards for their provider network to ensure access to care for members. These standards differ based on the provider type. For PCPs, the standard is 30 minutes or miles. For specialty care

providers the standard is 60 minutes or miles for 75 percent of the member population and 90 minutes or miles for 100 percent of the member population. Additional standards are in place for long-term care services and are based on whether or not the member lives in an urban or rural area of the state. Network geographic access reports are published quarterly on the DHS website: https://dhs.iowa.gov/ime/about/performance-data-GeoAccess

The Department's standards for access to care are further outlined in the MCO contracts. The MCOs use software to analyze their network and ensure providers are within the contractual time and distance standards. MCO provider network access is also reviewed annually during the EQR process. Contractually, the MCOs are required to ensure the following within their respective provider network:

AVAILABILITY OF SERVICES

- Maintain and monitor a network of appropriate providers.
- Provide female members with direct access to a women's health specialist.
- Provide for a second opinion from a qualified healthcare professional.
- Provide necessary services for a member that are not available in their network.
- Require out-of-network providers, or providers who are not contracted with the MCO, to work with the MCO regarding payment.
- Require timely access to services for members.
- Provide cultural considerations for members.

ASSURANCES OF ADEQUATE CAPACITY AND SERVICE

- Offer an appropriate range of preventative, primary care, and specialty services.
- Maintain a network of providers that is sufficient in number and geographic distribution.

COORDINATION AND CONTINUITY OF CARE

- Ensure that each member has an ongoing source of primary care.
- Coordinate all services that the member receives.
- Share identification and assessment information to prevent duplication of services for individuals with special healthcare needs.
- Protect member privacy in the process of coordinating care.
- Provides additional services for persons with special healthcare needs.

COVERAGE AND AUTHORIZATION OF SERVICES

- Identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer.
- Specify what constitutes "medically necessary services".
- Ensure that any decision to deny a service is made by an appropriate healthcare professional.

SERVICE DELIVERY

Utilization Reviews (UR)

Utilization management, or utilization review, is used by the MCOs to manage health care costs by evaluating the appropriateness of a member's care before they receive it. This is done through a variety of methods, including but not limited to prior authorization, medically necessity determination, member care coordination, DUR, and case-by-case assessments.

ACUTE CARE UR/EMERGENCY ROOM UR

Acute medical care reviews are completed by the MCOs for medical necessity of all members. This helps MCOs manage emergency room utilization of members.

UTILIZATION MANAGEMENT CARE COORDINATION

The MCO's utilization management care coordination program monitors members access to preventive care, particularly for members who are not accessing preventive care. This also helps identify member instances of over- and under-utilization of emergency room services. The MCO may conduct outreach to members identified during this UR to ensure members are receiving proper care.

LONG TERM SERVICE AND SUPPORTS (LTSS) UR

LTSS UR is conducted prior to a member's admission to a nursing facility to identify a member's need to receive specialized services, and to identify when there is a significant change in the member's need for services. The MCOs report these changes to the Department through a preadmission screening and resident review (PASRR) process.

DRUG UR

Federal regulations require state Medicaid programs to have a DUR program. Membership of the DUR program includes health care professionals who have recognized knowledge and expertise in one or more of the following: 1) The clinically appropriate prescribing of covered outpatient drugs; 2) The clinically appropriate dispensing and monitoring of covered outpatient drugs; 3) Drug use review, evaluation, and intervention; 4) Medical quality assurance. The goal of the DUR program is to ensure appropriate medication therapy, while permitting appropriate professional judgment to individualize medication therapy.

Pay for Performance (P4P) Program:

The Department has established a pay for performance program under which the MCO may receive compensation if certain conditions are met. Eligibility for compensation under the pay for performance program is subject to the MCO's complete and timely satisfaction of its obligations under the Contract. During each measurement year, the Department withholds a portion of the approved Capitation payment. The MCO may be eligible to receive some or all of the withheld funds based on the performance in the areas outlined below:

OPERATIONAL MEASURES

Operational measures address data submitted to the Department. For example accurate and timely encounter data submission to the Department and accurately paying providers in a timely manner.

HEALTH OUTCOMES MEASURES

Health Outcomes measures address access and quality of care a member receives. The Department uses national quality measures for this.

MEMBER-FOCUSED OVERSIGHT ACTIVITIES

Appeals

An appeal is a request for the MCO to review a decision that denies a benefit. A member or a member's authorized representative(s) may request an appeal following a decision made by an MCO to deny or limit items or services. Actions that a member may choose to appeal include:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required time-frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network.

Following the decision made by an MCO to deny or limit items or services, the member receives a letter explaining the MCO's reason for the denial or limitation of benefits. The member has 60 days from the date of the letter to contact their MCO and request to start the appeal process.

The appeal process starts with an internal review by the MCO of the member's denial or limitation of benefits. The MCO has 30 days to complete an internal review, and report, in writing, the findings of the review to the member. The MCO may choose to uphold, reverse, or modify their previous decision during this review.

If a member is not happy with the MCO's final decision, they can request a State Fair Hearing with the State with 120 days of the MCO's decision. Members must complete an appeal with their MCO before they can ask for a State Fair Hearing. Requests for a State Fair Hearing can be filed in person, by telephone, or in writing to DHS.

The State Fair Hearing process allows the member the opportunity to present their case to an administrative law judge (ALJ) for review. State Fair Hearings are legal proceedings, similar to a non-jury trial in a court of law, in which an impartial ALJ presides over the hearing. The ALJ's decision is final in these proceedings.

The Department uses clinical team of physicians, nurses, licensed social workers, and subject matter experts to review all State Fair Hearing appeals to determine if the MCO's initial decision to deny the service request was consistent or inconsistent with Iowa Administrative Code and/or state and federal criteria. The Department uses this review process as an oversight effort of the MCOs. The MCOs and/or providers typically receive additional education regarding the state's Medicaid policies and Iowa Administrative Code from the Department, following the clinical review of all State Fair Hearing appeals. A report of the Department's findings also is filed annually with the Legislature.

Grievances

Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative, or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:

- The member is unhappy with the quality of their care.
- A doctor who the member wants to see is not in their MCO's network.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by the MCO.
- Rights and dignity.
- The member is commended changes in policies and services.
- Any other access to care issues.

Members may file a grievance at any time by contacting their MCO. If a member is not satisfied with the MCO's resolution to their grievance, the member may be eligible to switch to a different MCO if certain criteria is met. The Department makes this determination.

Prior Authorizations

Some services or prescriptions require approval from the MCO for the item to be covered. This must be done before the member obtains the service or fills the prescription. Prior authorization is not required for procedures that occur during inpatient hospital or emergency room visits.

Prior authorization requests are completed by the member's PCP and sent to the MCO for approval. Services requiring prior authorization may not be received until they are approved by the member's MCO. The federal requirements for MCOs to make authorization decisions is 14 calendar days for standard authorization decisions, and within 72 hours after receipt for expedited authorization decisions. Expedited prior authorizations are made by the member's PCP to the MCO when they believe the member's life, health or ability to regain maximum function could be seriously harmed by waiting the standard 14 calendar days for a decision.

VALUE-ADDED SERVICES

Additional services provided and funded by the MCOs are referred to as value-added Services (VAS). The Department encourages the promotion of evidence-based programs and direct services that improve the health and well-being of Medicaid enrollees. VAS may be actual health care services, benefits, or positive incentives that will promote healthy lifestyles and improved health outcomes among members. Examples of VAS may include, but are not limited to, items such as: (i) incentives for obtaining preventive services; (ii) medical equipment or devices not already covered under the program to assist in prevention, wellness, or management of health conditions; (iii) supports to enable workforce participation; and (iv) cost effective supplemental services that can provide services in a less restrictive setting.

Each MCO offers a different set of VAS and the MCO can change the VAS it offers at any time.

A list of each MCO's current VAS can be found on the DHS website.

NON-COMPLIANCE REMEDIES

The primary goal of the Department is to ensure that the MCOs are delivering quality care to members. To assess attainment of this goal, the Department monitors certain quality and performance standards, and holds the MCOs accountable for being in compliance with contract terms. The Department accomplishes this by working collaboratively with the MCOs to maintain and improve programs.

In the event that the MCOs fail to meet performance requirements or reporting standards set forth in the contract or other standards established by the Department, written notice of non-compliance will be provided to the MCO and the corrective actions discussed below may apply.

Corrective Action Plans

The Department may require corrective action(s) and implement intermediate sanctions when the MCO has failed to provide the requested services. The nature of the corrective action(s) will depend upon the nature, severity and duration of the deficiency and repeated nature of the non-compliance. If the Department requires the MCO to conduct a corrective action plan, the plan shall be submitted under the signature of the MCO's chief executive and shall be approved by the Department. If the corrective action plan is not acceptable, the Department may provide suggestions and direction to bring the MCO into compliance.

Liquidated Damages

In the event that the MCO fails to meet performance requirements or reporting standards set forth in the contract, or other standards set forth by the Department, the Department may require the MCO to pay to the Department its actual or liquidated damages.

SUMMARY

Iowa uses a managed care approach to administer the majority of its Medicaid program. MCOs contract with DHS to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and long term services and supports. The Department pays a monthly capitation payment, similar to an insurance premium, to the MCOs for each member enrolled in the plan. The MCO then pays providers for the allowable services provided to Medicaid beneficiaries. By paying MCOs a fixed amount per member in advance, the MCOs are at financial risk if the cost of care exceeds this rate and thus, incentivizes them to provide value-based care. The MCOs are responsible for providing all covered Medicaid benefit services a beneficiary may need, as medically necessary. Additional services provided by the MCOs are referred to as value-added Services (VAS). The Department encourages the promotion of evidence-based programs and direct services that improve the health and well-being of Medicaid enrollees.

Members choose a PCP upon enrollment with an MCO. An unlimited number of visits is allowed and there is no cost associated with these visits. Members can change their PCP at any time. MCOs must ensure their members have access to Medicaid covered services in a timely manner through their established provider network. The provider networks are assessed by the Department for adequacy based on the availability of services, the ability to take additional or new patients, coordination and continuity of care, and coverage and authorization of services.

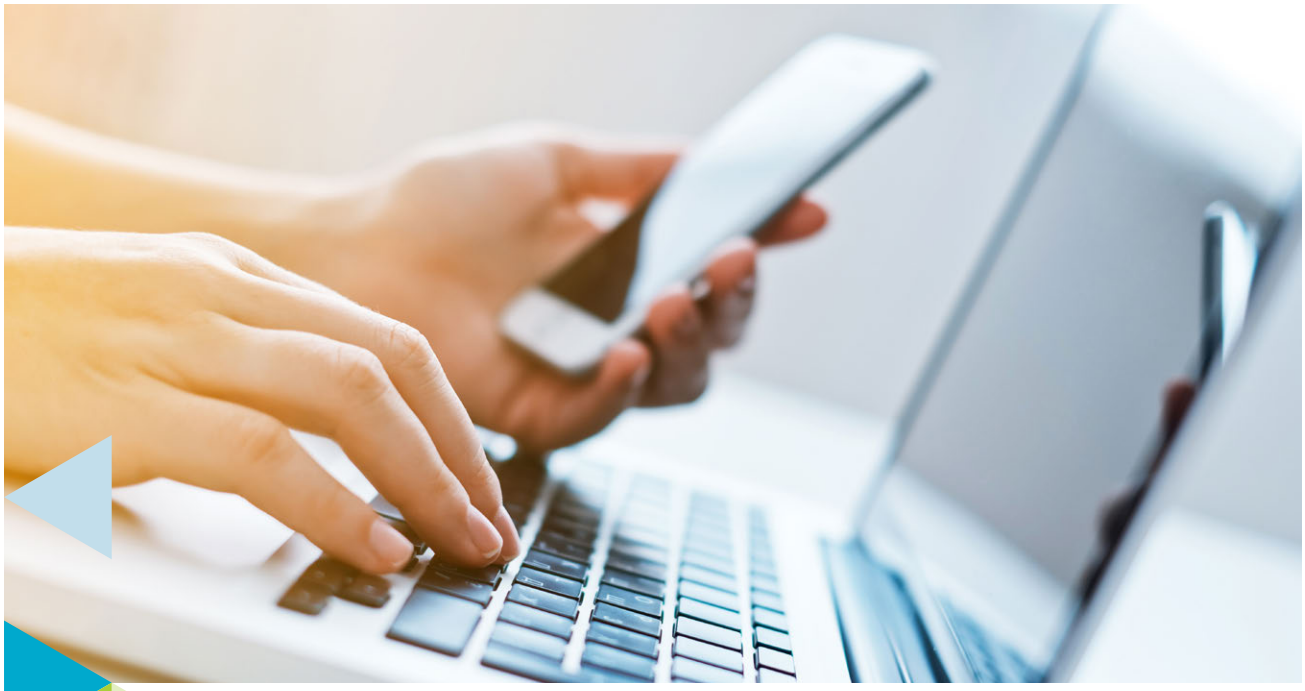
Performance monitoring and data analysis are critical components in assessing how well the MCOs are maintaining and improving the quality of care delivered to members. Multiple oversight tools are deployed in this effort. Annual evaluation activities include an external quality review and the evaluation of national performance measures. MCOs receive financial incentives for exceeding performance standards in key areas described in their contract with the State. P4P measures incentivize the MCOs to improve access, quality and timeliness of care provided to members.

MCOs also submit quality improvement data to the Department on a monthly, quarterly, and annual basis. These reports include documentation of MCO management of specific groups of Medicaid members, consumer supports, and program operations. The reports, with a number of elements required through oversight legislation, are comprehensive and focus on compliance areas, as well as health outcomes over time. The Department examines the data from a compliance perspective and conducts further analysis if any issues are identified. In addition, seven advisory councils are engaged in providing oversight of the Department's management of the state's Medicaid program.

Several utilization management strategies are in place to manage health care costs and ensure appropriate care is provided to members. A variety of methods, including but not limited to prior authorization, medically necessity determination, member care coordination, drug utilization review, and case-by-case assessments are incorporated into these strategies. Utilization review processes for acute care and emergency room services, care coordination, long term services and supports, and prescription drugs are in place.

Members may request an appeal following a decision made by an MCO, and maintain an option for a state fair hearing if the result of the appeal is not satisfying. Members also have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative, or provider who is acting on their behalf and has the member's written consent may file a grievance.

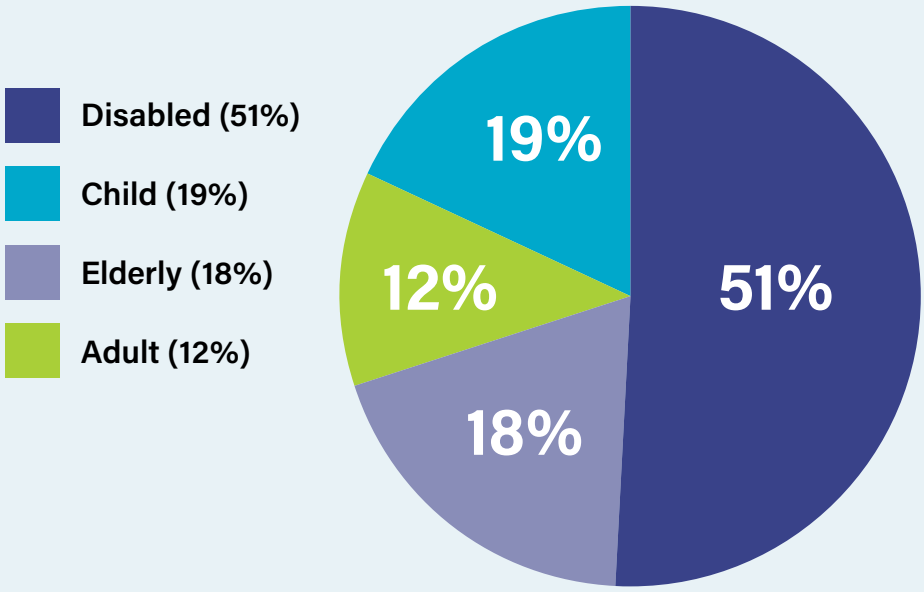
Finally, the Department monitors certain quality and performance standards to assure the MCOs are delivering quality care to members. These activities are collaborative efforts to maintain and improve programs. In the event that the MCOs fail to meet performance requirements or reporting standards set forth in the contract or other standards established by the Department, written notice of non-compliance will be provided to the MCO and corrective action plans and liquidated damages may be assigned as remedies.



Chapter 3:
What are the financial features of Medicaid/CHIP?

At a Glance

SFY20 Iowa Medicaid Expenditures



State Fiscal Year 2020 (SFY20) Iowa Medicaid Expenditures by Population Category (taken from: https://dhs.iowa.gov/sites/default/files/3_Improve_Iowans_Health_Status_4.pdf?090920201403, page 3-3)

Visit the following webpages for more information on the budget development and financials discussed in this chapter:

DHS Budget Report on Medicaid
https://dhs.iowa.gov/sites/default/files/3_Improve_Iowans_Health_Status_4.pdf?090920201403

SFY19 IA Health Link Managed Care Rate Development
https://dhs.iowa.gov/sites/default/files/IA%20Health%20Link%20SFY19%20Rate%20Certification%202018.07.13.pdf?011920212037

IME Provider Fee Schedules
https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Nursing Facility Rates
https://dhs.iowa.gov/ime/providers/csrp/nfr

Outpatient Hospital Rates
https://dhs.iowa.gov/ime/providers/csrp/outpatient-hospital

Pharmacy Point of Sale
http://www.iowamedicaidpos.com/

Iowa's Estate Recovery Law
https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery

BUDGET DEVELOPMENT

Iowa DHS staff, in coordination with the Department of Management and Legislative Services Agency, develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations requests. This process requires projections of the number of people eligible for the program; estimations of cost trends; and analyses of any new federal mandates or state changes affecting eligibility, services, or changes in program policy. Ultimately, decisions about funding are determined by the Governor and Legislature.

In addition, there are several factors that impact the state Medicaid budget, including what types of services Iowa chooses to cover and the amount of federal matching funds certain programs will receive.

The budget takes effect at the beginning of the state fiscal year in July. A significant amount of time elapses between the development of the initial agency budget request and the passage of a finalized appropriations bill.

APPROPRIATIONS TIMELINE

June - September	State agencies develop their budget requests. Agencies are required by statute to submit their budget requests for the upcoming fiscal year by October 1.
October - December	Department of Management works with department staff and the Governor's Office in reviewing and analyzing department requests.
January	Finalize Governor's Budget Recommendations.
January - May	The Legislature passes appropriation bills during the session (with most passed during the last week of the session usually in April/May).
April - June	The Governor has the option of signing the bill, item vetoing the bill or vetoing the bill entirely.
May - June	State agencies enter their spending plans based upon the enacted appropriations bills.
July	New fiscal year begins.

Matching Funds

The federal government guarantees matching funds to states for qualifying Medicaid expenditures. In some instances, the federal government provides a higher matching rate to states for select services or populations, such as Medicaid expansion or CHIP. In these instances, the federal government share is higher than the state's share or is on a gradual sliding scale.

CHIP/Hawki Benefits

Iowa implemented the Hawki program on January 1, 1999. The state's employee health plan is the benchmark for benefits available through the Hawki program. Similar to Medicaid, Hawki members receive health care services through a MCO and dental services through a dental plan.

BENEFITS

- Well-child and well-adolescent visits
- Vaccinations
- Inpatient hospital services, including medical, surgical, intensive care, mental health, and substance use.
- Outpatient hospital services, including emergency room surgery, lab, and x-ray.
- Nursing care services, including skilled nursing facility services.
- Physician services
- Ambulance services
- Physical therapy
- Speech therapy
- Durable medical equipment.
- Home health care
- Hospice services
- Prescription drugs
- Dental services
- Medically necessary hearing services
- Vision services, including corrective lenses.
- Translation and interpreter services
- Chiropractic services
- Occupational therapy

NON-COVERED BENEFITS

- Non-medical transportation
- Psychiatric Mental Institutes for Children (PMIC)
- Residential treatment

Mandatory and Optional Spending

There are mandatory Medicaid services that states are required to provide. States may also choose to offer optional benefits to Medicaid beneficiaries.

MANDATORY BENEFITS

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

OPTIONAL BENEFITS:

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal care services
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- Home and Community Based Services (HCBS)
- Self-Directed Personal Assistance Services
- Community First Choice Option
- Tuberculosis-related services
- Inpatient psychiatric services for individuals under age 21
- Health Homes for Enrollees with Chronic Conditions

RATE SETTING

The state pays the MCOs a monthly capitation rate, a fee based on each member assigned to the MCO each month, to provide care for its members.

Capitation rates must be reasonable (within a normal or acceptable range) and comply with all applicable laws for Medicaid managed care. The rate development process must comply with all applicable laws for the Medicaid program, including but not limited to, eligibility,

benefits, financing, any applicable waiver or demonstration requirements, and program integrity.

Capitation rates must be actuarially sound, which means the rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract.

The state uses an actuary to develop capitated rates for the MCOs. When developing capitated rates, an actuary will use a base data time period as the starting point of rate development, then add in the impact of policy changes, projection factors, and development of the MCO's non-medical load costs.

The state monitors the capitation rate through a medical loss ratio (MLR), which the MCOs are required to report. MLR is the sum of the MCO's incurred claims and expenditures for activities that improve health care quality divided by the amount the state paid to the MCO.

REIMBURSEMENTS FOR PHYSICIANS AND PHARMACIES

Physician and Other Professional Practitioner Services

Payment rates are based on a statewide fee schedule amount. The Iowa Legislature, Iowa Administrative Code, or the Centers for Medicare and Medicaid Services (CMS) may authorize changes to the fee schedule.

Pharmacy

Payment rates for prescription drugs dispensed by a pharmacy includes fees to cover the cost of ingredients, which are determined the Average Actual and Allowable Cost (AAC). After the ingredient cost is calculated, the cost of professional dispensing of the drugs is added to determine the reimbursement rate.

The AAC rate for the cost of ingredients are updated semi-annually. The cost of professional dispensing fee is updated every two years based on completion of a cost dispensing survey.

REIMBURSEMENTS FOR HOSPITALS AND OTHER CARE CENTERS

Inpatient and Outpatient Care

General acute care hospital reimbursement rates for FFS clients are set using a prospective payment system (PPS) based on the Medicare-Severity Diagnosis Related Group (MS-DRG) patient classification system. Under this system, each patient is classified into a diagnosis related group (DRG) on the basis of clinical information.

Hospitals are paid a provider-specific base rate for each DRG admission. Provider reimbursement is calculated by multiplying the provider-specific base rate by the relative weight for the assigned DRG. 'Outlier' payments are made in addition to the base DRG payment for patients whose treatments are exceptionally costly or who have long lengths of stay.

Inpatient hospital services provided in a certified physical rehabilitation unit or psychiatric unit are paid a provider-specific per diem rate.

Outpatient hospital services provided to FFS clients are reimbursed using the Ambulatory Payment Classification (APC) methodology. Under this system, each claim line item goes through the APC grouper to determine payment status.

If the claim line groups to an APC, the provider reimbursement is calculated by multiplying the provider-specific APC base rate by the relative weight for the assigned APC. Other claim lines may package (separate payment is not provided) to the paid lines or may be reimbursed using a statewide fee schedule amount.

'Outlier' payments are made for patients whose treatments are exceptionally costly.

Critical Access Hospitals are reimbursed at 100 percent of reasonable cost through a retrospective cost settlement. Interim payments are based on provider-specific DRG base rates for inpatient care and a percentage of covered charges for outpatient care.

Nursing Facilities

Nursing facilities are reimbursed for services provided to Medicaid residents through prospective quarterly case-mix-adjusted provider-specific per diem rates. There are two separate components in the Medicaid per diem rate – direct patient care and non-direct patient care. Case-mix is a score assigned to a resident based on the intensity of the services captured in the minimum data set (MDS), a federally required assessment tool. The quarterly case-mix adjustment is the average of case-mix for Medicaid residents for during a quarter.

Nursing facility cost reports are subjected to a desk review to determine whether reported costs are allowable. The Medicaid per diem rates are rebased every two years.

Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID)

Intermediate care facilities for individuals with an intellectual disability (ICF/IID) are reimbursed for services delivered to Medicaid residents through prospective provider-specific per diem rates. The Medicaid rate is calculated as the lower of the actual allowable per diem rate, the maximum allowable base rate, or the 80th percentile of allowable cost. The actual per diem rate is the amount determined during the annual desk review. The maximum allowable base rate is the prior year's base multiplied by the annual inflation factor. The base rate is reset every four years. The 80th percentile of allowable cost is determined annually ranking per diem costs from all ICFs/IID submitted costs to determine the percentile ranking.

ICF/IID cost reports are subjected to a desk review to determine whether reported costs are allowable. ICF/IID rates are updated annually.

Federally Qualified Health Centers and Rural Health Clinics

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs serve underserved areas or populations, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

A rural health clinic (RHC) is a clinic located in a rural area designated by the U.S. Health Resources and Services Administration as a shortage area. Medicare has a number of requirements in order for a clinic to qualify as an RHC, including that it must be located in a non-urbanized area that is medically underserved, as defined by the U.S. Census Bureau.

FQHCs and RHCs are reimbursed at the greater of 100 percent of the reasonable and allowable costs or the Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) Prospective Payment System (PPS) rate.

BIPA PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care. BIPA PPS rates may be updated if the FQHC or RHC has experienced a scope of service change. The scope of service change request must be approved by Iowa Medicaid.

HOSPITAL FUNDING

Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals without training programs. Historically, the Medicaid share of these additional costs have been covered by Graduate Medical Education (GME) payments to state-owned teaching hospitals.

GME payments cover the costs of residents' and teaching physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs. GME payments are not tied to specific services for Medicaid-eligible patients.

Iowa Medicaid is also authorized to provide supplemental payments for GME payments to state-owned teaching hospitals, specifically, the University of Iowa Hospitals and Clinics (UIHC).

An Intergovernmental Transfer (IGT) funds the non-federal share of GME payments made to UIHC and Broadlawns Medical Center (BMC). IGTs are a transfer of funds from UIHC and BMC to the state Medicaid agency before the GME payment is made. The ability to use IGTs to fund the non-federal share is in federal statute (§1903(w)(6) of the Social Security Act) and in federal rule (42 CFR §433.51).

Disproportionate Share Hospital Funding

Disproportionate Share Hospital (DSH) funding is special funding for hospitals that serve a disproportionately large number of Medicaid and low-income patients. DSH funds are not tied to specific services for Medicaid-eligible patients.

There are no federal or state restrictions on how disproportionate share hospitals can use their funds. Hospitals may use DSH payments to cover the uncompensated costs of care for indigent or low-income patients, including Medicaid patients.

The non-federal share is provided through a mix of state appropriation and IGT payments.

In order to qualify for DSH funds, hospitals must meet one of the following criteria:

- Low-Income Utilization Rate (LIUR) exceeds 25 percent
- Medicaid Inpatient Utilization Rate (MIUR) exceeds one standard deviation from the statewide average MIUR

- Children's hospitals or units are provided they meet federal and state qualification criteria.

Iowa Medicaid is also authorized to provide supplemental payments for DSH payments to state-owned teaching hospitals and non-state, government-owned teaching hospitals. The non-federal share of this payment is received through IGTs of funds from state-owned teaching hospitals and non-state, government-owned hospitals.

FUND RECOVERY

Member Costs

COPAYS

A majority of services are included at no cost to Medicaid members. Some Medicaid members are exempt from paying anything. A copay may apply to some Medicaid members for each visit to the Emergency Room that is not considered an emergency.

- Members of the Iowa Health and Wellness Plan (IHAWP) may be charged an $8 copay
- Hawki members may be charged a $25 copay
- All other Iowa Medicaid members may be charged a $3 copay

MONTHLY PREMIUMS/CONTRIBUTIONS

- Members of certain Medicaid and CHIP programs may be required to pay a monthly premium, or contribution, to continue to receive health care and dental services.
- Hawki members pay a monthly premium based on family size and income. No family pays more than $40 a month. Some families pay nothing at all.
- IHAWP members who do not complete Healthy Behaviors may be required to pay a monthly contribution to continue to receive health care and/or dental services each month.
- Members of the Medicaid for Employed People with Disabilities (MEPD) program pay a monthly premium based on their monthly gross income.

MEMBER LIABILITY/CLIENT PARTICIPATION

Some members have a member liability, also called client participation, requiring them to pay for part of the cost of the services they receive. The member liability must be met before Medicaid pays for covered services.

These members may be required to pay client participation:

- Members in an institutional setting
- Home- and Community-Based Services (HCBS) waiver members

If member liability applies, the provider will collect this amount from the member at the time services are received.

Third Party Liability

Third party liability (TPL) is the legal obligation of health care carriers to pay for all, or part, of a medical claim of a Medicaid beneficiary. By federal law, Medicaid is generally the payer of last resort, meaning that Medicaid only pays claims for covered items and services if there are no other liable third party payers.

Third party payments include health insurance benefits, settlements or court awards for casualty/tort (accident) claims, product liability claims, medical malpractice, and worker's compensation claims. (EPSDT services are not subject to TPL.)

Medicaid Estate Recovery Program

Federal law requires states to have an estate recovery program when Medicaid funds are used to pay for medical assistance, including the amount the state paid to an MCO for medical services. The estate recovery program applies to people who are 55 years old or older at the time they get Medicaid and people who are under age 55 and live in a long-term care facility, and are not expected to return home.

When a person who gets medical assistance dies, their assets must be used to repay the Department for the money that was spent on medical care. Estate recoveries are used to pay future program costs helping the Department continue to ensure that Iowa's most vulnerable citizens have access to critical healthcare services.

SUMMARY

DHS staff coordinate with the Department of Management, and the Legislative Services Agency to form the basis for Medicaid funding requests which are ultimately decided by the Governor and Legislature. This process requires projections of the number of people eligible for Medicaid; estimations of cost trends; and analyses of any new federal mandates or state changes affecting eligibility, services, or changes in program policy. Several factors impact the state Medicaid budget, including what types of services Iowa chooses to cover, provider reimbursement rates, and the amount of federal matching funds certain programs will receive.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures. There are mandatory services that states are required to provide and states may also choose to offer optional benefits through their MCOs.

The state pays the MCOs a monthly capitation rate, a fee based on each member assigned to the MCO each month, to provide care for its members. Capitation rates must be reasonable (within a normal or acceptable range) and comply with all applicable laws for Medicaid managed care. Capitation rates must be actuarially sound, which means the rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract.

Physician and other professional practitioner services and pharmacy services are paid using a fee-for-services methodology. Hospitals and other care centers, nursing facilities, intermediate care facilities, federally qualified health centers, and rural health clinics have separate reimbursement methodologies that apply to their unique circumstances. Hospitals that operate medical residency training programs and hospitals that serve a disproportionately large number of Medicaid and low-income patients also receive payments from the state's Medicaid program.

Medicaid payments are protected by two mechanisms. Third Party Liability (TPL) and the Estate Recovery Program (MERP). TPL ensures Medicaid's status as the payer of last resort. MERP supports recovery of the costs of medical assistance provided to people who are 55 years old or older at the time they get Medicaid and people who are under age 55 and live in a long-term care facility, and are not expected to return home. Both TPL and MERP help keep the state's future costs of Medicaid down, as it ensures Medicaid funds are being used appropriately.

Chapter 4

What is Medicaid/CHIP's Governing Framework?

At a Glance

Key Federal Concepts

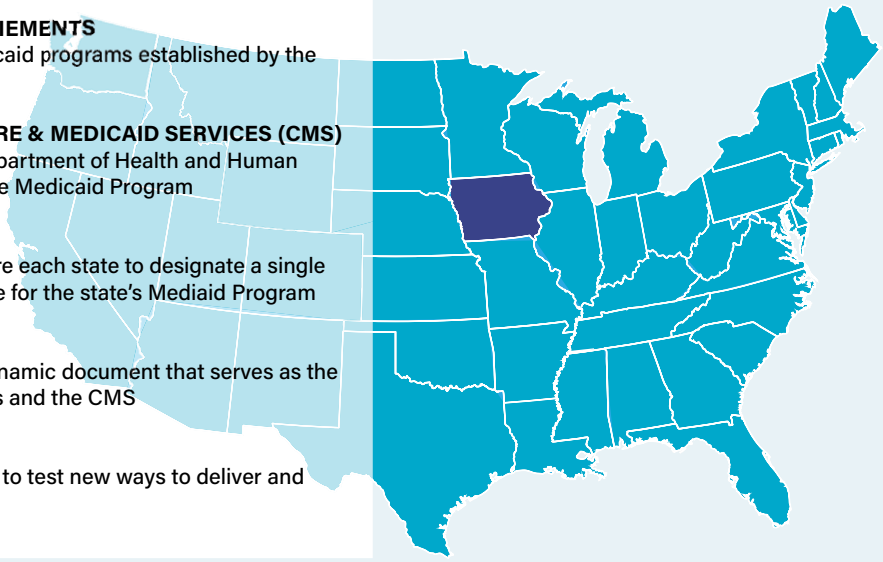
FUNDAMENTAL REQURIEMENTS
Basic Principles for Medicaid programs established by the Social Secrity Act

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
Agency within the US Department of Health and Human Services that oversees the Medicaid Program

SINGLE STATE AGENCY
Federal regulations require each state to designate a single state agency responseible for the state's Mediaid Program

MEDICAID STATE PLAN
Submitted by states, a dynamic document that serves as the contract between statews and the CMS

WAIVERS
How states apply to CMS to test new ways to deliver and pay for services.



Medicaid operates according to the following fundamental requirements

1. **STATEWIDE AVAILABILITY**
   All Medicaid services must be available statewide and may not be restricted to residents of particular localities.
2. **SUFFICIENT COVERAGE**
   States must cover each service in an amount, duration, and scope that is "reasonably sufficient."
3. **SERVICE COMPARABILITY**
   The same level of services must be available to all clients, except where federal law specifically requries a broader range of services or allows a reduced package of services.
4. **FREEDOM OF CHOICE**
   Clients must be allowed to go to any Medicaid healthcare provider who meets program standards.

Key Federal Mandate Categories

SERVICES
States must provide mandated services and may provide certain optional services.

POPULATIONS
States must cover certain groups and set percentages of the FLP, and may expand coverage to optional groups.

LIMITS
States may not impose limits on services for Medicaid clients age 20 and younger, nor may a state arbitratily limit services for any specific illness or condition.
States may limit utilization of some services, such placing a limit on the number of prescriptions per month for outpatient drugs.

STATE PLANS

As required by the Social Security Act, Sections 1902 and 2101, states must have a CMS-approved document, known as a state plan, for the Medicaid and CHIP programs in order to receive federal matching funds. The state plan also designates DHS as the single state Medicaid agency for Iowa, authorizing the agency to administer the Medicaid and CHIP programs in Iowa. While federal law provides much of the framework for these programs, states have the ability to make operational and policy decisions to best reflect the needs of members, including nature and scope of client eligibility, benefits, and provider reimbursement.

As discussed in Chapter 1, state Medicaid and CHIP programs are required to cover certain categorical eligibility groups, such as children and pregnant women, as well as provide mandatory benefits to enrolled members of these eligibility groups. However, states also have the option to add coverage for additional eligibility groups and provide benefits beyond those mandated by CMS. The state plan sets forth which optional groups and services the state has chosen to implement.

The state plan is not a static document. Whenever Iowa wishes to make changes to the Medicaid or CHIP programs, such as adding new benefits mandated by state law, the state must submit a state plan amendment (SPA) to CMS for consideration and approval before operationalizing such changes.

1915(i) HCBS State Option

States can establish additional HCBS benefits under a 1915(i) waiver to meet the specific needs of a populations within Federal guidelines through submission of a state plan amendment, including:

- Establish a process to ensure that assessments and evaluations are independent and unbiased
- Ensure that the benefit is available to all eligible individuals within the State
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that the HCBS are provided in accordance with a person-centered service plan
- Establish a quality assurance, monitoring and improvement strategy for the benefit

Iowa's 1915(i) waiver has been dedicated to supporting Habilitation Services. As noted in Chapter 1, Habilitation Services is a program to provide HCBS for Iowans with impairments typically associated with chronic mental illnesses. Habilitation Services are designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

MEDICAID WAIVERS

In accordance with Sections 1115 and 1915 of the Social Security Act, states may apply to CMS for permission to depart from—or waive—certain federal requirements. States may seek waivers to reflect their own needs and priorities through implementation of creative ways to improve delivery of and payment for Medicaid services. Federal law provides for three main types of waivers: Section 1115 research and demonstration waivers, Section 1915(b) managed care waivers, and Section 1915(c) Home and Community-based Services (HCBS) waivers. Iowa currently utilizes each of these types of waivers.

1115 Research and Demonstration

Section 1115 waivers allow states to test new or existing ideas or models for operating Medicaid programs. CMS requires states to monitor, evaluate, and report these waivers to ensure their effectiveness. In Iowa, the state uses its 1115 waiver to implement the Iowa Wellness Program (IWP), including the Dental Wellness Program (DWP). Originally approved in 2013 and extended in 2016 and 2019, this waiver, in combination with associated SPAs, enables Iowa to expand Medicaid coverage to two adult groups, providing coverage for those with incomes up to 133% FPL. The demonstration further allows the state to charge premiums to members of these adult groups with income above 50% FPL and implement the Healthy Behaviors program as described in Chapter 1. The waiver also allows the state to operate Prepaid Ambulatory Health Plans which increase access to dental services for the adult Medicaid population. Finally, Iowa's 1115 waiver allows the state to implement retroactive eligibility for specified populations.

The goals of this 1115 demonstration waiver are divided between the IWP and DWP. The IWP seeks to further the objectives of Title XIX of the Social Security Act by:

1. Improving enrollee health and wellness through the encouragement of healthy behaviors and use of preventive services.
2. Increasing enrollee engagement and accountability in their health care.
3. Increasing enrollee's access to dental care.

Additionally, the DWP seeks to achieve the following goals related to dental services:

1. Ensure member access to and quality of dental services.
2. Allow for the seamless delivery of services by providers.
3. Improve the oral health of DWP enrollees by encouraging engagement in preventive services and compliance with treatment goals.
4. Encourage linkage to a dental home.

1915(b) Managed Care

Section 1915(b) waivers allow states to deliver Medicaid services through a manged care delivery system. In Iowa, the state's 1915(b) waiver provides the authority for IA Health Link managed care program, which serves approximately 96 percent of the state's Medicaid enrollees through two managed care organizations, or MCOs (see Chapter 3).

Iowa's goals for the IA Health Link initiative include:

1. Creation of a single system of care that delivers efficient, coordinated health care and promotes accountability in health care coordination;

2. Improvement in the quality of care and health outcomes for members;
3. Integration of care across the health care delivery system;
4. Emphasis of member choice and increased access to care;
5. Increased program efficiencies and budget accountability;
6. Continued rebalancing efforts to provide community-based rather than institutional care, when appropriate; and
7. Holding MCOs responsible for outcomes.

1915(c) HCBS

Section 1915(c) waivers allow members to receive long-term services and supports at home or in community settings as an alternative to receiving services in institutional settings, such as nursing homes or intermediate care facilities for persons with intellectual disabilities (ICF IDs). Iowa operates seven different HCBS waivers:

- Health and Disability Waiver
- AIDS/HIV Waiver
- Elderly Waiver
- Intellectual Disability Waiver
- Brain Injury Waiver
- Physical Disability Waiver
- Children's Mental Health Waiver

For more information on these waivers, refer to Chapter 1.

FUNDAMENTAL REQUIREMENTS

Section 1902 of the Social Security Act also establishes the statutory framework for certain fundamental requirements of state Medicaid programs. These four key principles are outlined below.

Statewide Availability

This requirement—also referred to as "statewideness"—mandates that state Medicaid programs provide the same benefits to all members in a given eligibility category throughout the state, not limited by geography or delivery system (i.e., managed care or FFS). Iowa has established contractual standards for the MCOs to ensure statewideness, including network adequacy standards accounting for time and distance, as well as appointment availability (see Chapter 3).

States may request to waive this principle via one of the Medicaid waivers discussed above.

Amount, Duration, and Scope

Amount, duration, and scope refers to how much of, how long, and to what extent a service is covered, regardless of whether the service is mandatory or optional. Per federal code, each service a state provides through its Medicaid program must be sufficient in amount, duration, and scope to reasonably achieve its purpose. CMS allows each state, via its state plan, to determine what constitutes reasonably sufficient coverage and to establish utilization control and medical necessity procedures.

Service Comparability

Federal law prohibits states from placing limits on services or denying or reducing coverage due to a particular illness or condition, except where federal law requires a broader range of services or allows a reduced package of services. In some cases, additional steps have been taken to increase access to care for certain demographic groups.

COVERAGE FOR CHILDREN

All states must provide the EPSDT benefit for children and youth under age 21 (see Chapter 1). This unique service is a comprehensive benefit intended to proactively discover and treat childhood health conditions, whether medical, developmental, or behavioral in nature. Additionally, under EPSDT, child and youth members are entitled to any medically necessary and appropriate health care service covered by Medicaid, regardless of any limitations to that service included in the state plan.

MENTAL HEALTH PARITY

The federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance coverage for mental health and substance use disorders to be no more restrictive than coverage for medical or surgical conditions, also known as parity. State Medicaid and CHIP programs must comply with these parity provisions, as well, to help create consistency and prevent inequity with commercial insurance plans. CMS regulations extend parity protections to apply to long-term care services for mental health and substance use, and further require states to include parity standards in MCO contracts.

Freedom of Choice

With limited exceptions, states must ensure members have freedom of choice to receive services from any qualified and willing provider, including choice between MCOs. Exceptions may occur through special contractual options or via waiver requests to CMS. This provision does not prohibit states from establishing fees for providers or setting reasonable standards relating to the qualifications of providers.

Resources

- Iowa Admin Code 441 Title VIII, Managed Care: https://www.legis.iowa.gov/law/administrativeRules/rules?agency=441&chapter=73&pubDate=08-31-2016
- Iowa Code 249A (Medical Assistance), 249N (Health and Wellness Plan), 514I (Hawk-I)
  https://www.legis.iowa.gov/docs/code/249A.pdf
  https://www.legis.iowa.gov/docs/code/249N.pdf
  https://www.legis.iowa.gov/docs/code/514I.pdf
- Social Security Act, Title XIX: https://www.ssa.gov/OP_Home/ssact/title19/1900.htm [waivers at section 1915]
- 42 CFR Ch. IV: https://www.ecfr.gov/cgi-bin/text-idx?SID=f45ccd460062732da313cbbd53944287&mc=true&tpl=/ecfrbrowse/Title42/42chapterIV.tpl
- Reference guide for federal statutes and regulations: https://www.macpac.gov/reference-guide-to-federal-medicaid-statute-and-regulations/
- Iowa Medicaid state plan documents: https://dhs.iowa.gov/ime/about/stateplan/medicaid
- CMS state plan amendments: https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html?f%5B0%5D=state%3A696#content
- Iowa DHS policy manuals: https://dhs.iowa.gov/policy-manuals
- Social Security Act, Section 1115: https://www.ssa.gov/OP_Home/ssact/title11/1115.htm
- CMS state waivers list: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f%5B0%5D=waiver_state_facet%3A696#content

SUMMARY

As required by the Social Security Act, Sections 1902 and 2101, states must have a CMS-approved document, known as a state plan, for the Medicaid and CHIP programs in order to receive federal matching funds. Changes can be made to the state plan through a request submitted to CMS for consideration and approval.

States may apply to CMS for permission to waive certain federal requirements using three main types of waivers: Section 1115 research and demonstration waivers, Section 1915(b) managed care waivers, and Section 1915(c) Home and Community-based Services (HCBS) waivers. Iowa currently utilizes each of these types of waivers. The waivers reflect the state's needs and priorities and to implement improvements for the delivery of and payment for Medicaid services.

Section 1902 of the Social Security Act also establishes the statutory framework for certain fundamental requirements of state Medicaid programs. There are four key principles within this framework. They are: statewide availability; amount, duration, and scope; service comparability with coverage for children and mental health parity as major components; and freedom of choice.

APPENDIX A: HELPFUL WEBSITES

Website Name	Link	What You'll Find
DHS Services Portal	https://dhsservices.iowa.gov/apspssp/ssp.portal	Information about eligibility for Medicaid and how to apply for Medicaid
Medicaid Member Services	https://dhs.iowa.gov/ime/members	Information about services, identifying a provider, member rights and responsibilities, key contacts, and a listing of member resources
Medicaid Member Resources	https://dhs.iowa.gov/ime/members/member-resources	A listing of where members can call for help with various different Medicaid and DHS services.
Medicaid Provider Services Contact Directory	https://dhs.iowa.gov/ime/about/contacts/provider-services	A listing of contact information for Medicaid providers.
Amerigroup Iowa	https://www.myamerigroup.com/ia/iowa-home.html	Information for Amerigroup members, an Iowa Medicaid MCO.
Iowa Total Care	https://www.iowatotalcare.com/	Information for Iowa Total Care members, an Iowa Medicaid MCO.
Delta Dental of Iowa	https://www.deltadentalia.com/dwp/	Information for Delta Dental members, a dental plan providing benefits to some Medicaid adults and children enrolled in the Hawki program.
MCNA Dental	https://www.mcnaia.net//en/home/	Information for MCNA members, a dental plan providing benefits to some Medicaid adults.
PACE Service Providers	https://immanuel.com/our-communities#desmoines https://immanuel.com/pathways-pace/southwest-iowa/about https://www.unitypoint.org/siouxcity/services-pace.aspx	Information about the PACE services provider in the covered counties.

Website Name	Link	What You'll Find
Consumer Choices Option Services Provider	https://www.veridianfiscalsolutions.org/cco/#:~:text=Consumer%20Choices%20Option%20(CCO)%20is%20an%20Iowa%20Medicaid,more%20flexibility%20over%20how%20their%20services%20are%20provided.	Information about the services available through this program's provider, Veridian.
Managed Care Organization (MCO) Monthly Demographic Reports	https://dhs.iowa.gov/ime/about/performance-data/MC-monthly-reports	Demographic reports are published each month identifying the Medicaid population by program, MCO, and Fee-for-Service, and by county.
MCO Performance Reports	https://dhs.iowa.gov/ime/about/performance-data	Managed Care annual, quarterly, and monthly reports, geographic access reports, a Medicaid infographic, and other reports
Managed Care Contracts and Rates Information	https://dhs.iowa.gov/MED-16-009_Bidders-Library	All contracts, amendments for MCOs and Dental Plans, and rate information
Medicaid Managed Care Annual Reports	https://dhs.iowa.gov/ime/about/performance-data/annualreports	MCO annual performance reports, external quality review reports, and NCQA health plan ratings
MCO Summary	https://dhs.iowa.gov/sites/default/files/Comm504.pdf?011220212056	Contact information, benefits, and Value-Added Services for both MCOs
DHS Budget Report on Medicaid	https://dhs.iowa.gov/sites/default/files/3_Improve_Iowans_Health_Status_4.pdf?090920201403	Departmental report on Medicaid including financial data
Provider Fee Schedules	https://dhs.iowa.gov/ime/providers/csrp/fee-schedule	Fee schedules by service type
Iowa's Estate Recovery Law	https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery	Description, forms, and contact information for Estate Recovery
Social Security Act, Title XIX	https://www.ssa.gov/OP_Home/ssact/title19/1900.htm	Federal guidance to Title XIX grants to states (Medicaid)

Website Name	Link	What You'll Find
Electronic Code of Federal Regulations	https://www.ecfr.gov/cgi-bin/text-idx?SID=f45ccd460062732da313cbbd53944287&mc=true&tpl=/ecfrbrowse/Title42/42chapterIV.tpl	Subchapter C shares the federal guidance for Medical Assistance Programs for the Centers For Medicare and Medicaid Services (CMS)
MAC PAC: Medicaid and CHIP Payment and Access Commission	https://www.macpac.gov/reference-guide-to-federal-medicaid-statute-and-regulations/	Reference guide to federal Medicaid statute and regulations
Iowa Medicaid State Plan Documents	https://dhs.iowa.gov/ime/about/stateplan/medicaid	Listing of all relevant state plan documents for Iowa Medicaid
Centers for Medicare and Medicaid Services (CMS) State Plan Documents	https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html?f%5B0%5D=state%3A696#content#content	Iowa Medicaid's State Plan Amendments shared by CMS
Medicaid Provider Manuals	https://dhs.iowa.gov/policy-manuals/medicaid-provider	Policy manuals by provider type
Social Security Administration, Compilation of the Social Security Laws	https://www.ssa.gov/OP_Home/ssact/title11/1115.htm	Medicaid demonstration projects (Section 1115)
CMS State Waivers List	https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f%5B0%5D=waiver_state_facet%3A696#content	Listing of Iowa's Medicaid waivers
Federal Information on Medicaid	https://www.medicaid.gov/	Federal policy and resources on Medicaid.
Iowa Code 514	https://www.legis.iowa.gov/docs/code/514.pdf	Iowa Code on Nonprofit Health Service Corporations
Iowa Code 249A	https://www.legis.iowa.gov/docs/code/249A.pdf	Iowa Code on Medical Assistance
Iowa Code 249N	https://www.legis.iowa.gov/docs/code/249N.pdf	Iowa Code on Iowa Health and Wellness Plan

APPENDIX B: GLOSSARY

Adult Day Care: An organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care setting.

AIDS/HIV Waiver: A HCBS waiver that offers services for those who have been diagnosed with AIDS or HIV.

Adverse Benefit Determination: A written notice to a member or provider to explain an action being taken.

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO. Actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required time-frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with DHS or they may ask to ask for a state fair hearing.

Brain Injury (BI) Waiver: A HCBS waiver that offers services for those who have been diagnosed with a brain injury due to an accident or an illness.

Capitation Expenditures: Medicaid payments the Department makes on a monthly basis to the MCOs for member health coverage. MCOs are paid a set amount for each enrolled person assigned to that MCO, regardless of whether services are used that month. Capitated rate payments vary depending on the member's eligibility.

Care Coordinator: A person who helps manage the health of members with chronic health conditions.

Case Manager: See Community Based Case Management (CBCM)

Centers for Medicare and Medicaid Service (CMS): A federal agency that administers the Medicare program and works in partnership with state governments to administer Medicaid standards.

Children's Mental Health (CMH) Waiver: A HCBS waiver that offers services for children up to age 18, who have been diagnosed with a serious emotional disturbance.

GLOSSARY

Children's Health Insurance Program (CHIP): A federal program administered by state governments to provide health care coverage for children and families whose income is too high to qualify for Medicaid, but too low to afford individual or work-provided health care.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

Community: A natural setting where people live, learn, work, and socialize.

Community Based Case Management (CBCM): Helps LTSS members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. CBCMs make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (CDAC): Helps people do things that they normally would for themselves if they were able. CDAC services may include unskilled tasks such as bathing, grocery shopping, household chores or skilled tasks such as medication management, tube feeding, recording vital signs. CDAC providers are available through an agency or from an individual such as a family member, friend, or neighbor that meets eligibility requirements.

Copayment (Copay): Some medical services have a copayment, which is your share of the cost. If there is a copayment, you will pay it to the provider. The provider will tell you how much it is.

Durable Medical Equipment (DME): Reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

Elderly Waiver: A HCBS waiver that offers services for elderly persons. An applicant must be at least 65 years of age.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT): A program of preventive health care for children, including well-child exams with appropriate tests and shots, which is called the Care for Kids program in Iowa.

Fee-for-Service: The payment method by which the state pays providers for each medical service given to a patient.

Fee Schedule: A fee schedule is a complete listing of fees used by Medicaid to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers.

Financial Ratios: The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for MCOs is contractually set at 89%.
- Administrative Loss Ratio (ALR): The percent of capitated rate payments an MCO spends on administrative costs.
- Medical Loss Ratio (MLR): The percent of capitated rate payments an MCO spends on claims and expenses that improve health care quality of Medicaid members.
- Underwriting Ratio (UR): If total expenses exceed capitated rate payments, an underwriting loss occurs. If total capitated rate payments exceed total expenses, an underwriting profit occurs.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:
- Member is unhappy with the quality of your care
- Doctor who the member wants to see is not in the MCO's network
- Member is not able to receive culturally competent care
- Member got a bill from a provider for a service that should be covered by the MCO
- Rights and dignity
- Member is commended changes in policies and services
- Any other access to care issues

Habilitation (Hab) Services: Services provided under an HCBS program to Iowans with the functional impairments typically associated with chronic mental illness.

Health & Disability (HD) Waiver: A HCBS waiver that offers services for those persons who are blind or disabled. An applicant must be less than 65 years of age for this waiver.

Healthy and Well Kids in Iowa (Hawki): In Iowa, CHIP is offered through the Hawki program. Hawki offers health coverage, through a MCO, for uninsured children of working families. A family who qualifies for Hawki may have to pay a monthly premium. No family pays more than $40 a month.

Home Health Aide: Medical services that provide direct personal care. This may include assistance with oral medications, eating, bathing, dressing, personal hygiene, accompanying member to medical services, transporting member to and from school or medical appointments, and other necessary activities of daily living that is intended to prevent or postpone institutionalization.

Homemaker Services: Services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance. Homemaker service is limited to essential shopping, limited house cleaning, and meal preparation.

Home and Community Based Services (HCBS): Types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.

Home Delivered Meals: Meals that are prepared outside of the member's home and delivered to the member.

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Intellectual Disability (ID) Waiver: A HCBS waiver that offers services for persons who have been diagnosed with an intellectual disability.

Intermediate Care Facilities for the Intellectually Disabled (ICF/ID): The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities, and specifies that these institutions must provide "active treatment," as defined by the Secretary. Currently, all 50 States have at least one ICF/IID facility. This program serves over 100,000 individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. All must qualify for Medicaid assistance financially.

Inpatient Admissions: A member has formally been admitted to a hospital to receive care.

Iowa Health and Wellness Plan (IHAWP): The Iowa Health and Wellness Plan covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act or Medicaid expansion.

Iowa Insurance Division (IID): The state regulator which supervises all insurance business transacted in the state of Iowa.

Iowa Medicaid Enterprise (IME): The division of DHS that administers the Iowa Medicaid and CHIP Programs.

Level of Care (LOC): Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long Term Services and Supports (LTSS): Medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities of daily living, such as bathing, dressing, eating, transfers, and toileting, and/or activities that are essential to daily living, such as housework, preparing meals, taking medications, shopping, and managing money.

Managed Care Organization (MCO): A health plan contracted with DHS to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and LTSS.

Medicaid: Provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. Also known as Title XIX under the Social Security Act.

Nursing Facility (NF): Provides 24-hour care for individuals who need nursing or skilled nursing care.

Non-Emergency Medical Transportation (NEMT): Services are for members with full Medicaid benefits, who need travel reimbursement or a ride to get to their medical appointments.

Physical Disability (PD) Waiver: A HCBS waiver that offers services for persons who are physically disabled. An applicant must be at least 18 years of age, but less than 65 years of age.

Prior Authorization (PA): Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription.

Primary Care Provider (PCP): A physician, a physician assistant or nurse practitioner, who directly provides or coordinates member health care services. A PCP is the main provider the member will see for checkups, health concerns, health screenings, and specialist referrals.

Program Integrity (PI): Program Integrity (PI) is charged with reducing fraud, waste and abuse in the Iowa Medicaid program.

Provider: A provider is a health care professional who offers medical services and support.

Provider Network Access: Each MCO has a network of providers across Iowa who their members may see for care. Members don't need to call their MCO before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the MCO network. There may be times when a member needs to get services outside of the MCO network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to the member than if provided in-network.

Psychiatric Medical Institute for Children (PMIC): Institutions which provide more than 24-hours of continuous care involving long-term psychiatric services to three or more children in residence. The expected periods of stay for diagnosis and evaluation are fourteen days or more and for treatment the expected period of stay is 90-days or more.

Referral: A referral means that your primary care provider must give you approval to see someone that is not your primary care provider. If you don't get approval we may not cover the services. There are certain specialists in which you do not need a referral, such as women's health specialists.

Service Plan: Plan of services for HCBS members. A member's service plan is based on the member's needs and goals. It is created by the member and their interdisciplinary team to meet HCBS Waiver criteria.

Specialist: Specialists are health care professionals who are highly trained to treat certain conditions.

Temporary Assistance for Needy Families (TANF) Adult and Child: A program to help needy families achieve self-sufficiency.

Third-Party Liability (TPL) Recovered: Third party payments include recoveries from health insurance coverage, settlements or court awards for casualty/tort (accident) claims, product liability claims (global settlements), medical malpractice, worker's compensation claims, etc. This means all other available TPL resources must meet their legal obligation to pay claims for the care of an individual eligible for Medicaid. By law, Medicaid is generally the payer of last resort, meaning that Medicaid only pays claims for covered items and services if there are no other liable payers.

Value Added Services (VAS): Optional benefits provided by the MCOs.

Value Based Purchasing (VBP) Agreement: An agreement that holds health care providers accountable for both the cost and quality of care they provide by providing payment to improved performance.

Waivers: See Home and Community Based Services (HCBS) or specific waivers listed above.

Waiver Service Plan: See *Service Plan*

APPENDIX C: WAIVERS AND HABILITATION ELIGIBILITY

Department of HUMAN SERVICES **Medicaid Long Term Support Services (LTSS) Comparison Chart:**
Home- And Community-Based Waiver Services

	AIDS/HIV Waiver	Brain Injury Waiver	Children's Mental Health Waiver	Elderly Waiver	Health and Disability Waiver	Intellectual Disability Waiver	Physical Disability Waiver	Habilitation
Age	No age limit	Age 1 month or older	Under age 18	Age 65 or older	Under age 65	No age limit	Age 18 through 64	Age 16 or older
Target Population	Diagnosis of AIDS/HIV	Brain injury diagnosis as set forth in rule 441—83.81(249A)	Diagnosis of serious emotional disturbance	Age 65 or over	▪ Blind or disabled ▪ Supplemental Security Income (SSI)-related coverage groups	Primary disability of intellectual disability determined by a psychologist or psychiatrist	Physical disability as determined by Disability Determination Services	Income at or below 150% Federal Poverty Level (FPL)
Level of Care (LOC) **Required***	Nursing Facility (NF) or Hospital	NF, Skilled Nursing Facility (SNF), or Intermediate Care Facility for individuals with an Intellectually Disability(ICF/ID)	Hospital	NF or SNF	NF , SNF, or ICF/ID	ICF/ID	NF or SNF	Meet needs-based eligibility criteria as determined by a Needs-Based Evaluation – interRAI-MH Core Standardized Assessment Meets 1 of 2 risk factors and meets at least 2 of 5 criteria showing a need for assistance for at least two years Be determined by the Iowa Medicaid Enterprise (IME), Medical Services to be able to live in a home or community based setting where all medically necessary service needs can be met
Care Coordinator	▪ Case Manager (CM) or ▪ Community Based Case Manager (CBCM)	▪ CM or ▪ CBCM	▪ CM or ▪ Integrated Health Home (IHH) Care Coordinator or ▪ CBCM	▪ CM or ▪ CBCM	▪ CM or ▪ CBCM	▪ CM or ▪ CBCM	▪ CM or ▪ CBCM	▪ CM or ▪ IHH Care Coordinator or ▪ CBCM
Maximum Dollars Available Per Month (As determined by LOC)	▪ $1876.80	▪ $3,013.08 ▪ Excluding cost of Case Management & Home and Vehicle Modification (HVM)	▪ $2,006.34 ▪ Excluding cost of Environmental Modification	▪ NF $1,365.78 ▪ SNF $2,792.65 ▪ Excluding cost of Case Management & HVM	▪ NF $959.50 ▪ SNF $2,792.65 ▪ ICF/ID $3,742.93 ▪ Excluding cost of HVM	▪ ICF/ID – Amount based on services upper limits	▪ $705.84 ▪ Excluding cost of HVM	▪ Not Applicable – State Plan
Adult Day Care	x	x		x	x	x		
Assistive Devices				x				
Assisted Living				x				
Behavioral Programming		x						
Case Management Services		x		x				x
Chore				x				
Community Based Neurobehavioral Rehabilitation Services (CNRS)								
Consumer Choices Option (CCO)	x	x		x	x	x	x	
Consumer Directed Attendant Care (CDAC)	x	x		x	x	x	x	
Counseling	x				x			
Day Habilitation						x		x

Medicaid Long Term Support Services (LTSS) Comparison Chart:
Home- And Community-Based Waiver Services

	AIDS/HIV Waiver	Brain Injury Waiver	Children's Mental Health Waiver	Elderly Waiver	Health and Disability Waiver	Intellectual Disability Waiver	Physical Disability Waiver	Habilitation
Emergency Response		x		x	x	x	x	
Environmental Modifications and Adaptive Devices			x					
Family and Community Support			x					
Family Counseling & Training		x						
Home Based Habilitation								x
Home Delivered Meals	x			x	x			
Home Health Aide	x			x	x	x		
Homemaker	x			x	x			
Home/Vehicle Modifications		x		x	x	x	x	
In-home Family Therapy			x					
Interim Medical Monitoring & Treatment		x			x	x		
Mental Health Outreach				x				
Nursing	x			x	x	x		
Nutritional Counseling				x	x			
Prevocational Services *includes Career Exploration		x				x		x
Respite: Individualized, group, specialized	x	x	x	x	x	x		
Senior Companion				x				
Supported Community Living (SCL)		x				x		
Specialized Medical Equipment		x					x	
Supported Community Living: Residential-Based (RBSCL) **for children**						x		
Supported Employment (SE)		x				x		x
Transportation		x		x		x	x	

HCBS Regional Specialists (HCBS Waiver and State Plan HCBS Habilitation)	Visit **www.dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts** for a listing of HCBS Regional Specialist assignments.
Where to apply?	**HCBS Waiver:** Local DHS income maintenance office or online at: https://dhsservices.iowa.gov/apspssp/ssp.portal **HCBS Habilitation:** To apply for Habilitation, the member must first be Medicaid eligible. Application for Habilitation is made by the IHH Care Coordinator or CBCM submitting a request for Habilitation to the IME Medical Services Unit or the managed care organization submitting a completed assessment and social history to the IME Medical Services Unit.
Determination of financial eligibility	**HCBS Waiver and HCBS Habilitation:** DHS income maintenance worker. Review of Medicaid eligibility is completed every 12 months. **Habilitation:** Member's that are eligible for Medicaid state plan benefit coverage and have income at or below 150% FPL are financially eligible for Habilitation
Determination of LOC	**HCBS Waiver and HCBS Habilitation:** IME Medical Services or Managed Care Organization (MCO). Core Standardized Assessment and LOC Completed at least once every 12 months or when there is a significant change in the member's situation or condition.
Development of service plan	**HCBS Waiver and HCBS Habilitation:** CM, CBCM, IHH Care Coordinator. Service plan completed after waiver/ state plan HCBS eligibility determination approval and annually thereafter. Service plan must be completed, and services authorized, prior to service provision.
Provider Enrollment	**HCBS Waiver and HCBS Habilitation:** Providers must enroll with IME and MCOs to be providers of service. Providers must be fully enrolled and be authorized in a service plan prior to service provision.
Initial Date of Eligibility	Waiver eligibility effective date will be determined when the following eligibility requirements are completed: financial (income & resource) eligibility is determined and level of care is established. Waiver services provided before approval of eligibility for the waiver, or prior to service plan authorization, cannot be paid. The **Habilitation** eligibility date is the first date that the IME was able to determine that the member met the needs based and risk based criteria for the Habilitation program.