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State/Territory Name: IA

State Plan Amendment (SPA) #: 13-16

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

APR 25 2014

Charles M. Palmer, Director
Iowa Department of Human Services
1305 East Walnut, 5th Floor
Des Moines, Iowa 50319-0114

RE: Iowa State Plan Amendment TN: 13-016

Dear Mr. Palmer:

We have reviewed the proposed amendment to Attachment 4.19-A, Attachment 4.-19-B, Supplement 2 to Attachment 4.19-B, and Supplement 2 to Attachment 3.1-A of your Medicaid State plan submitted under transmittal number (TN) 13-016. This amendment provides for a one percent (1%) increase in payment rates for inpatient and outpatient hospital services..

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 13-016 is approved effective July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Cindy Mann
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 13 — 016

2. STATE: IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY '13 $ 1,704,541.56
b. FFY '14 $ 6,677,944.18

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, Page 12, 24 25 26b
Attachment 4.19-B, Page 1, 1c, 1d, 1b
Supplement 2 to Attachment 4.19-B, Page 14, 22
Supplement 2 to Attachment 3.1-A, Page 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-A, Page 12, 24 25 26b
Attachment 4.19-B, Page 1, 1c, 1d, 1b
Supplement 2 to Attachment 4.19-B, Page 14, 22
Supplement 2 to Attachment 3.1-A, Page 16

10. SUBJECT OF AMENDMENT

2013 SF 446 Conference Committee Report increased Medicaid provider rates for certain provider types and services.

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 8-21-13

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR 25 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy + Financial Mgt. CMCS

23. REMARKS:

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

9. Trending Reimbursement Rates Forward

The final payment rate for the current rebasing uses the hospital's base-year cost report. The only adjustments made to this rate are for fraud, abuse, and material changes brought about by cost report re-openings done by Medicare or Medicaid.

The rates have been trended forward using inflation indices of 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, 0.0% for SFY 2003, 0.0% for SFY 2004, 0.0% for SFY 2005, 3.0% for SFY 2006, 3.0% for SFY 2007, 0.0% for SFY 2008, and 11.0% for SFY 2009. For services beginning on December 1, 2009, rates shall be reduced by 5.0%. For services beginning on October 1, 2010, rates effective June 30, 2010, shall be increased by 20.46% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices. For services beginning on August 1, 2011, rates effective July 31, 2011, shall be increased by 76.94% except for the University of Iowa Hospital and Clinics and out-of-state hospitals. For services beginning on October 1, 2011, rates effective September 30, 2011, shall be decreased by 41.18% except for the University of Iowa Hospital and Clinics and out-of-state hospitals.

Rates effective November 1, 2011, and thereafter, have been trended forward by 5.72%. Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices. For services beginning on July 1, 2012, rates effective June 30, 2012, shall be increased by 9.89%, except for the University of Iowa Hospital and Clinics and out-of-state hospitals. This rate increase is effective for services rendered during July 1, 2012-September 30, 2012.

For services beginning on July 1, 2013, rates effective June 30, 2013, shall be increased by 1.00%.

Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

10. Ceilings and Upper Limit Requirements

Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost. This principle is not altered by the DRG reimbursement methodology.

At the end of the cost reporting period, the aggregate covered charges for the period are determined and compared to the aggregate payments made to the hospital under the DRG payment methodology (before any subtraction of third-party payments). If the aggregate covered charges are less than the aggregate payments made using the DRG rates, the amount by which payments exceed the covered charges is requested and collected from the hospital.

This adjustment is performed each year at the end of the hospital's fiscal year, and does not have any impact upon the DRG rates that have been calculated for the next year. There is no carryover of unreimbursed costs into future periods under this DRG reimbursement methodology.

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

29. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

b. Allocation to Fund for Direct Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for September 1, 2011, through June 30, 2012, is $6,265,918.94. Thereafter, the total annual amount of funding that is allocated is $7,519,102.73. Effective July 1, 2013, the total annual amount of funding that is allocated is $7,594,294.03

A reduction of this amount will be made if a hospital fails to qualify for direct medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

c. Distribution to Qualifying Hospitals for Direct Medical Education

Distribution of the amount in the fund for direct medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

1. Multiply the total of all DRG weights from the GME/DSH Fund apportionment claim set, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

d. Qualifying for Indirect Medical Education

Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

e. Allocation to Fund for Indirect Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for September 1, 2011, through June 30, 2012, is $11,097,594.96. Thereafter, the total annual amount of funding that is allocated is $13,317,113.95. Effective July 1, 2013, the total annual amount of funding that is allocated is $13,450,285.14.

A reduction of this amount will be made if a hospital fails to qualify for indirect medical education payments from the fund. This occurs if a hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. The amount of money that would have been paid to that hospital will be removed from the fund.

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

h. Allocation to Fund for Disproportionate Share

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share related to inpatient services for December 1, 2009, through June 30, 2010, is $6,890,959. Thereafter, the total annual amount of funding that is allocated is $6,890,959. Effective July 1, 2013, the total annual amount of funding that is allocated is $6,959,868.59.

i. Distribution to Qualifying Hospitals for Disproportionate Share

Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims from the GME/DSH Fund apportionment claim set, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and the Medicaid utilization rate (or for children's hospitals during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age will be used in the forgoing formula.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and enhanced disproportionate share payments describe in Section 30 cannot exceed the amount of the federal cap under Public Law 102-234.

State/Territory: IOWA

ATTACHMENT 4.19-B
METHODS AND STANDARDS
FOR
ESTABLISHING PAYMENT RATES
FOR
STATE PLAN COVERED SERVICES

A. When services which are reimbursed per a fee schedule, unless otherwise noted below, the same fee schedule applies to all providers -- both public and private -- and the fee schedule and any annual/periodic adjustments to the fee schedule are published at the Iowa Medicaid Agency's website at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html. Except for Other Independent Laboratory services, the agency's rates were set as of July 1, 2013, and are effective for services on or after that date. The fee schedule amounts are located at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html.

The fee schedule amounts for Other Independent Laboratory services, including code series 81000 are based on 100% of the Medicare Clinical Laboratory Fee Schedule. Effective January 1, 2009, and annually thereafter, the Department shall update the Independent Laboratory fee schedule using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

B. The principles and standards established in OMB Circular A-87 are applied, when applicable, in determining rates regardless of the reimbursement methodology or fee schedule described below.

C. Rates paid for individual practitioner services based on the fee schedule or methodology described below shall not exceed the provider's customary charges for the service billed. In order for the Iowa Medicaid Agency to meet the requirements of 42 CFR 447.203(b)(1) providers of individual practitioner services must bill Medicaid the customary charge for the service provided.

D. Providers of services must accept reimbursement based upon the Iowa Medicaid agency fee or methodology without making any additional charge to the recipient.

E. All payments are made to providers. The term "provider" means an individual or an entity furnishing Medicaid services under an agreement with the Iowa Medicaid agency. An entity need not be a facility such as a hospital, ICF/MR, or nursing. Pursuant to 42 CFR 447.15 (g), the term may include facilities or entities who employ or contract with persons who are authorized under the Iowa State Plan to provide covered services. Also an entity may provides, for example, "clinic services (as defined in 42 CFR 440.90)" or "home health services (as defined in 42 CFR 440.70) and other services which are otherwise covered under Iowa Medicaid through its employees or contractors. In the latter case the entity would also be paid for those non-clinic and

State/Territory: IOWA

or non-home health services if it had an employment contract or other contract with the licensed health care professional providing those services which meets the requirements of 42 CFR 447.15(g).

F. Below is a description of the methods and standards for establishing rates for all covered services other than waiver services. The numbering and description of is identical to the list of covered services contained in ATTACHMENT 3.1-A. **(Continued on page 2 of Att. 4.19-B)**

State/Territory: IOWA

The following services will be modified:

Various services applicable to fee schedule language on page 1 (Physician Services; Podiatrist Services; Optometrist Services; Chiropractor Services; Audiology Services; Hearing Aide Dispenser Services; Psychologist Services; Services of Advanced Registered Nurse Practitioners; Services of Certified Nurse Anesthetists; Certain Pharmacists Services; Services of Advanced Nurse Practitioners Certified in Psychiatric or Mental Health Specialties; Renal Dialysis Clinics; Ambulatory Surgical Centers; Maternal Health Centers; Home Health-Medical Supplies and Equipment; Physical Therapy Services; Occupational Therapy Services; Services for Individuals with Speech, Hearing and Language Disorders; Prosthetic Devices; Eyeglasses; Nurse Midwife Services; Extended Services for Pregnant Women; Ambulatory Prenatal Care for Pregnant Women during a Presumptive Eligibility Period; Nurse Practitioner Services; Transportation Services) – Effective for services rendered on or after September 1, 2011, reimbursement will be 95% of the agency's rates set as of July 1, 2008, excluding IowaCare network providers. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%, excluding IowaCare network providers. (Page 1 of Attachment 4.19-B)

Ambulance Services – Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 10%. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered between December 1, 2009 and December 31, 2009, reimbursement will be made at 95% of Medicare's January 1, 2009 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Independent Laboratory Services – Effective for services rendered on or after January 1, 2010, reimbursement will be 95% of Medicare's January 1, 2010 clinical laboratory fee schedule. (Page 1 of Attachment 4.19-B)

Various services applicable to fees schedule language on page 1 (Dental Services; Dentures; Medical and Surgical Services Furnished by a Dentist) – Effective for services rendered on or after December 1, 2009, reimbursement will be 97.5% of the agency's rates set as of July 1, 2008. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%. (Page 1 of Attachment 4.19-B)

Preventative Exam Codes rendered in connection to services provided by IowaCare network providers – Effective for services rendered on or after December 1, 2009, reimbursement will be 95% of the agency's rates set as of July 1, 2008. (Page 1 of Attachment 4.19-B)

EPSDT: Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 5 of Attachment 4.19-B)

Family Planning Services – Agency's rates were set as of July 1, 2008, and are effective for services rendered on or after that date. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%. (Page 1 of Attachment 4.19-B)

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Home Health-Intermittent Nursing Services – Effective for services rendered on or after December 1, 2009, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at November 30, 2009, less five percent; or the base year Medicare per visit limitations plus inflation. (Page 8 of Attachment 4.19-B)

Effective for services rendered on or after July 1, 2012, reimbursement made at the lower of: the home health agency's average cost per visit per the Medicare cost report; the agency's rate in effect at June 30, 2012, plus two percent; or the base year Medicare per visit limitations plus inflation (Page 8 of Attachment 4.19-B).

Community Mental Health Centers – Effective for services rendered December 1, 2009 through June 30, 2010, reimbursement will be reduced to 97.5% of reconciled cost. (Page 9, of Attachment 4.19-B)

Rehabilitation – Effective for services rendered on or after December 1, 2009, reimbursement will be 100% of cost, not to exceed 110% of the statewide average allowable cost less 5% (Page 12 of Attachment 4.19-B)

Hospital-Specific Base APC Rates – Effective for services rendered on or after December 1, 2009, all reimbursement rates will be reduced by 5%, excluding IowaCare network providers. Effective for services rendered on or after July 1, 2013, reimbursement rates will be increased by 1%, excluding IowaCare network providers. (Page 14 of Supplement 2 of Attachment 4.19-B)

Graduate Medical Education and Disproportionate Share Pool – Effective from December 1, 2009, the total annual pool amount that is allocated to the Graduate Medical education and disproportionate share pool for direct medical education related to outpatient services is $2,776,336. (Page 22 of Supplement 2 of Attachment 4.19-B).

Physician Services Rendered in Facility Settings – Effective for services rendered on or after September 1, 2011, site of service differentials will be applied to certain professional services rendered by physicians with a facility place of service. The site of service differential will only apply to those CPT/HCPCS codes that Medicare has determined to be eligible for site of service payment differentials under that program. The list of CPT/HCPCS procedures codes affected are posted at the following website: http://www.ime.state.ia.us/Reports_Publications/FeeSchedule.html.

Effective for services rendered on or after April 25, 2012 and through December 31, 2012, site of service differentials will not be applied to certain professional services rendered by physicians with a facility place of service. Effective for services rendered on or after July 1, 2013, site of service differentials will no longer be applied to services rendered by physicians in a hospital setting, pursuant to state legislative mandate. The site of service differentials previously applied to those CPT/HCPCS codes that Medicare has determined to be eligible for site of service payment differentials under that program. Effective July 1, 2013, all services provided by physicians in a hospital setting will be reimbursed using the non-facility rate.

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

5. Calculation of the hospital-specific base APC rates

a. The final payment rate for the current rebasing uses the hospital's base-year cost report. The rates have been trended forward using inflation indices of 2.0% for SFY 2000, 3.0% for SFY 2001, (3.0%) for SFY 2002, 0,0% for SFY 2003, 0.0% for SFY 2004, 0.0% for SFY 2005, 3.0% for SFY 2006, 3.0% for SFY 2007, 0.0% for SFY 2008, and 1.0% for SFY 2009. For services beginning on December 1, 2009, rates shall be reduced by 5.0%. For services beginning on July 1, 2010, rates effective June 30, 2010, shall be increased by 13.74% except for the University of Iowa Hospital and clinics and out-of-state hospitals. For services beginning on August 1, 2011, rates effective July 31, 2011, shall be increased by 3.38% except for the University of Iowa Hospital and clinics and out-of-state hospitals. For services beginning on January 1, 2012, rates effective December 31, 2011, shall be increased by 11.14% except for the University of Iowa Hospital and clinics and out-of-state hospitals. This rate increase is effective for services rendered during January 1, 2012-June 30, 2012. For services beginning on July 1, 2012, rates effective June 30, 2012, shall be increased by 13.56% except for the University of Iowa Hospital and clinics and out-of-state hospitals. This rate increase is effective for services rendered during July 1, 2012-September 30, 2012.

For services beginning on July 1, 2013, rates effective June 30, 2013, shall be increased by 1.00%.

Rates of hospitals receiving reimbursement as critical access hospitals are not trended forward using inflation indices.

b. Using the hospital's base year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

c. The cost to charge ratios are applied to each line item charge reported on claims in the Medicaid claim set, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

State/Territory: IOWA

Methods and Standards for Establishing Payment Rates for Other Types of Care

Outpatient Hospital Care (Cont.)

15. Recovery of Overpayments

When The Department determines that an outpatient hospital provider has been overpaid, a notice of overpayment and request for refund is sent to the provider. The notice states that if the provider fails to submit a refund or an acceptable response within 30 days, the amount of the overpayment will be withheld from weekly payments to the provider.

16. Rate Adjustment for Hospital Mergers

When one or more hospitals merge to form a distinctly different legal entity, the base rate is revised to reflect this new operation. Financial information from the original cost reports and the original rate calculations is added together and averaged to form the new rate for that entity.

17. Graduate Medical Education and Disproportionate Share Fund

Payment is made to all hospitals qualifying for direct medical education directly from the Graduate Medical Education and Disproportionate Share Fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

a. Qualifying for Direct Medical Education

Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

b. Allocation to Fund for Direct Medical Education

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services for September 1, 2011, through June 30, 2012, is $2,282,771.11. Thereafter, the total annual amount of funding that is allocated is $2,739,325.33. Effective July 1, 2013, the total annual amount of funding that is allocated is $2,766,718.25.

State/Territory: IOWA

(1) Iowa Medicaid Agency in its provider manual which manual manipulation is appropriate treatment.

An x-ray must document the primary regions of subluxation being treated. No x-ray is required for pregnant women and for children age 18 and younger. This x-ray is covered by Iowa Medicaid if it otherwise meets the requirements for a covered x-ray under Item 3 Attachment 3.1.1-A.

6d1. RESERVED

6d2. RESERVED

6d3. RESERVED

6d4. SERVICES OF HEARING AID DISPENSERS
Iowa Medicaid covers only those services of hearing aid dispensers related to hearing aids prescribed by a licensed audiologist or physician (M.D. or D.O.).

6d5a. PSYCHOLOGY
Iowa Medicaid covers services by licensed psychologists within the scope of the psychologist's licensure.

6d5b. SOCIAL WORKER PROVIDER
Iowa Medicaid covers services by a licensed social worker, within the scope of his or her license, when provided as part of a written plan of treatment. The services may also be provided by a Medicare certified home health agency.

6d6. BEHAVIORAL HEALTH PROVIDER
Iowa Medicaid covers services provided by a licensed marital and family therapist and licensed mental health counselor, within the scope of his or her license as part of a written plan of treatment. Iowa Medicaid covers services provided by a alcohol and drug counselor certified by the Iowa Board of Certification.

6d7. RESERVED