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State/Territory Name: IA

State Plan Amendment (SPA) #: 19-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Kansas City Regional Operations Group

December 27, 2019

Michael Randol, Medicaid Director
Division of Medical Services
Department of Human Services
Iowa Medicaid Enterprise
611 Fifth Avenue
Des Moines, IA 50309

Dear Mr. Randol:

On September 20, 2019, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #19-0013. This SPA increased available services to members on the basic benefit package. In particular, denture related services were added. During the SFY19 it was revealed that members with dentures in the basic benefit tier did not have access to the needed services.

SPA #19-0013 was approved December 18, 2019, with an effective date of August 30, 2019, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Iowa State Plan.

If you have any questions regarding this amendment, please contact Karen Hatcher or Laura D'Angelo at (816) 426-5925.

Sincerely,

Megan K. Buck, Acting Director
Division of Program Operations

Enclosure

cc:
Mikki Stier, Deputy Director, DHS
Jennifer Steenblock
Alisa Horn
Jeff Marston

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: 19 — 01 3

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
August 30, 2019 ~~July 1, 2019~~ *

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 2019 $ 182,451.98
b. FFY 2020 $ 745,273.57

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 2 to Attachment 3.1-A, Page 24
Supplement 2 to Attachment 3.1-A, Pages 30 and Page 30a (New Page) **

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 2 to Attachment 3.1-A, Page 24
Supplement 2 to Attachment 3.1-A, Page 30 **

10. SUBJECT OF AMENDMENT

This increased available services to members on the basic benefit package. In particular, denture related services were added. During SFY19 revealed member with dentures in the basic benefit tier did not have access to the needed 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: GERD W. CLABAUGH

14. TITLE: INTERIM DIRECTOR

15. DATE SUBMITTED: 9-30-19

16. RETURN TO
GERD W. CLABAUGH
INTERIM DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/30/19

18. DATE APPROVED: 12/18/19

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 08/30/19

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: Megan K. Buck

22. TITLE: Acting Director, Division of Program Operations

23. REMARKS

* Pen and Ink change authorized via state response dated 11.20.19.

** Pen and Ink change authorized via state response dated 12.16.19.

on July 27, 2017, and represents a subset of the full dental benefits listed above.

1. Periodic evaluation - *Limitation*: Maximum of 2 per 12 months, 6 months apart.
2. Comprehensive evaluation - *Limitation*: maximum of 1 every 3 years per dentist.
3. Problem focused evaluation
4. Periodontal comprehensive evaluation - *Limitation*: maximum of 1 per 12 months.
5. Oral prophylaxis, including necessary scaling and polishing - *Limitation*: Once in 6-month period except for persons who, because of physical or mental disability, need more frequent care.
6. Periodontal maintenance - *Limitation*: maximum of once every 3 months.
7. Pulp vitality test
8. Sedation
9. Tooth re-implantation/splinting
10. Incision and drainage of abscess
11. Radiographs including periapical, bitewing, and panoramic. *Limitation*: panoramic radiograph has a maximum of 1 every 5 years, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases.
12. Pulpal debridement and pulpotomy
13. Office visit after regularly scheduled hours
14. Biopsy
15. Palliative treatment of dental pain
16. Extraction and surgical removal of residual tooth roots
17. Surgical extraction, impactions
18. Caries risk assessment
19. Fluoride application
20. Interim caries arresting medicament application
21. Dentures, including repairs and adjustments, as further described in item 12b on pages 30 and 30a of Supplement 2 to Attachment 3.1-A

A. Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

B. Payment of supplemental rebates results in a drug being included on the preferred drug list and/or the recommended drug list.

C. Drugs of manufacturers who do not participate in the supplemental rebate program will be made available to Medicaid beneficiaries through prior authorization.

D. Supplemental rebates are for the Medicaid population only.

E. Participation in the SSDC multi-state rebate agreement will not limit the state's ability to negotiate state-specific supplemental rebate agreements.

12b. DENTURES

Dentures, including repairs and adjustments are covered under the Medicaid state plan based on medical necessity and subject to the following limitations. The denture limitations described below many be exceeded based on medical necessity and with prior authorization.

A. An immediate denture or a first-time complete denture including six months' post-delivery care when provided to establish masticatory function. Limitations: Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.

B. Removable and fixed partial dentures require prior authorization. Limitations: A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a documented physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.

C. Replacement dentures. Limitations: Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five-year period. Prior authorization may be obtained if replacement is medically necessary prior to the expiration of the five-year period. Prior authorization is also allowed for more than one

denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

D. Relines. Limitation: Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.

E. Tissue conditioning. Limitation: Covered twice per prosthesis in a 12-month period.

F. Repairs. Limitation: Only two repairs per prosthesis are allowed in a 12-month period.

G. Obturator. Limitation: For surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

H. Adjustments to a complete or removable partial denture. Limitation: If medically necessary after six months' post-delivery care.

12c. PROSTHETIC DEVICES

Prosthetic devices are not covered when dispensed to a patient before the patient undergoes a procedure which will make the use of the device necessary.

The following prosthetic and orthotic devices are covered:

a. Prosthetic devices other than dental, that replace all or a part of an internal body organ, including colostomy bags and supplies, directly related to colostomy care, including-
   (i) Replacement of prosthetic devices; and
   (ii) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intralocular lens is insert.
b. Leg, arm, back and neck bracers and artificial legs, arms and eyes, including replacements if required because of a change in the individual's physical condition.
c. Durable planter foot orthotic;
d. Plaster impressions for foot orthotic;
e. Molded digital orthotic;
f. Shoe padding when appliances are not practical;