Table of Contents

State/Territory Name: Iowa

State Plan Amendment (SPA) #: 22-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

May 19, 2022

Elizabeth Matney
State Medicaid Director
Iowa Department of Human Services
1305 E. Walnut Street, Hoover Building, FL-1
Des Moines, Iowa 50309

Re: Iowa State Plan Amendment (SPA) 22-0006

Dear Ms. Matney:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0006. This amendment establishes compliance with mandatory Medicaid coverage and reimbursement of routine patient costs furnished in connection with participation in qualifying clinical trials.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and Sections 1905(a)(30) and 1905(gg)(1). This letter is to inform you that Iowa Medicaid SPA 22-0006 was approved on May 18, 2022, with an effective date of January 1, 2022.

If you have any questions, please contact Michala Walker at 816-426-6503 or via email at Michala.Walker@cms.hhs.gov .

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Jennifer Steenblock
Hornaday, Tashina
Lee Herko

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Iowa**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

IA-22-0006

Proposed Effective Date

01/01/2022 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1905(a)(30) and 1905(gg)(1) as required by section 210 of the Consolidated Appropriations Act (CAA)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	22	$ 0.00
Second Year	23	$ 0.00

Subject of Amendment

Ensure iowa Medicaid appropriately covers and pays for the costs of items and services for beneficiaries enrolled in qualifying clinical trials, in accordance with SMD Letter 21-0005 issued December 7, 2021.

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Jennifer Steenblock**
Last Revision Date:	**May 12, 2022**
Submit Date:	**Mar 30, 2022**

Alternative Benefit Plan

State Name: Iowa | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IA - 22 - 0006 | OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Iowa Wellness Plan

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Iowa Health and Wellness Plan members with countable income that does not exceed 100% of the federal poverty level shall be enrolled in the Iowa Wellness Plan unless the member is determined by the Department to be a medically exempt individual. Iowa Health and Wellness Plan members with countable income between 101% and 133% of the federal poverty level may be enrolled in the Iowa Wellness Plan unless the individual can be enrolled in a Marketplace Choice plan or the member is determined by the Department to be a medically exempt individual.

Individuals with income between 101% and 133% of the federal poverty level will be enrolled in a Marketplace choice plan provided through designated qualified health plans available on the health insurance marketplace only when there are two or more plans available.

Regardless of their FPL, persons who have access to cost-effective ESI will be enrolled in their ESI as the primary payer. Any eligible services not provided by the member's employer sponsored plan will be covered under the Iowa Wellness Plan. Persons with income up to 133% of the FPL who have an exempt individual status, as defined by 42 CFR 440.315, will be enrolled in the ABP that is the Medicaid State Plan and will have the option to enroll in the Iowa Wellness Plan ABP.

PRA Disclosure Statement

V.20140415

Alternative Benefit Plan

State Name: Iowa

Attachment 3.1-L- 1

OMB Control Number: 0938-1148

Transmittal Number: IA - 22 - 0006

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☐ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

After the state receives a member survey from the member, the state will determine whether the member has an exempt individual status as defined at 45 CFR 440.315. Iowa will then mail the member letter informing them of their enrollment options.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

Members will simply need to call the Iowa Medicaid Member Services unit and request to change plans. The member can change plans at any time. Iowa would like to clarify, however that the ABP defined using section 1937 requirements does not actually cover all the 1937 requirements. Exemptions to the 1937 requirements are included in the Iowa Wellness Plan 1115 waiver/Special Terms and Conditions document and include waiver of NEMT services Iowa's attestations about this ABP are not meant to indicate that the ABP will comply with the requirements of 1937, only that the benefit plan is defined statutorily in section 1937.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

☐ In the eligibility system.

☐ In the hard copy of the case record.

☒ Other

Describe:

Iowa will keep all correspondence regarding the member (wheterh sent form or received by Iowa) in a secure computer system.

What documentation will be maintained in the eligibility file? (Check all that apply)

☐ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☒ Other

Describe:

Only eligibility information will be in the member's eligibility file. Iowa has other systems that maintain correspondence and documentation about the member.

Alternative Benefit Plan

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

V.20160722

Alternative Benefit Plan

State Name: Iowa

Attachment 3.1-L- 1

OMB Control Number: 0938-1148

Transmittal Number: IA - 22 - 0006

Enrollment Assurances - Mandatory Participants ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Iowa has created a referral form to be used for providers or other entities with a relationship with the member. The form will ask for attestation of the conditions that qualify a person as an exempt individual. When providers or approved entities submit this form, Iowa will then review the form to determine whether the individual meets the criteria of an exempt individual.

☒ Self-identification

Describe:

Iowa will utilize a self-attestation method of screening via affirmative answers to two questions on the single-streamlined application regarding receipt of Social Security income and/or having a physical, mental, or emotional health condition that causes limitations in activities of daily living. If an individual answers affirmatively to either or both questions, they will receive a questionnaire to assess whether they may have an exempt individual status as described in 42 CFR 440.315. When the member completes/returns the questionnaire, the responses will be reviewed to calculate (based on a weighted scoring algorithm) whether or not the member meets the criteria of an exempt individual. The member can return this form at any time for a determination of their status. If the member does not return the form, s/he will remain in the Iowa Wellness plan.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☒ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☒ Change in eligibility group

☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

○ Monthly

○ Quarterly

○ Annually

○ Ad hoc basis

◉ Other

Describe:

Self identification will be done at enrollment and annual re-enrollment. However, persons may self-identify at any time by completing the questionnaire or contacting the Iowa Medicaid Enterprise for assistance in doing so. Additionally, provider/ entity referrals may be made at any time.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

If an exempt individual contacts the Iowa Medicaid Enterprise requesting to be dis enrolled from the ABP, the IME will dis enroll and provide him or her the other Alternative Benefit Plan available to the member. Coverage in the new plan will be effective on the 1st of the following month.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

If an individual is determined by Iowa to be exempt as defined by 45 CFR 440.315, th member will be enrolled in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan and will have the option to change coverage to the Alternative Benefit Plan knowns as the Iowa Wellness Plan.

PRA Disclosure Statement

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- (•) The state/territory is amending one existing benefit package for the population defined in Section 1.
- ( ) The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Iowa Wellness Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- (•) Benchmark Benefit Package.
- ( ) Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ( ) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ( ) State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ( ) A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- (•) Secretary-Approved Coverage.
  - ( ) The state/territory offers benefits based on the approved state plan.
  - (•) The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Iowa will use a combination of benefits that include: the state employee coverage offered and generally available to state employees, the Medicaid State Plan for the prescription drug benefit, and a commercial dental carrier for dental services. Members will have access to emergency, stabilization, diagnostic, and preventive services as part of the core benefit of the dental plan. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Alternative Benefit Plan

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ◉ Any of the largest three state employee health benefit plans by enrollment.
- ○ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Plan name: Wellmark Inc Blue Access

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. Yes

☐ The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

Through it's Iowa Wellness Plan 1115 waiver, Iowa is waiving the 'Comparability' requirements of SSA 1902(a)(17). This will enable Iowa to provide coverage through different delivery systems for different populations of Medicaid beneficiaries.

V.20130807

Alternative Benefit Plan

State Name: Iowa

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IA - 22 - 0006

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Wellmark Blue Access State Employee Plan

The "Benefit Provided" field lists the name of each benefit the same way it was described in the Section 1115 Waiver. If the name (but same benefit) was different in the Base Benchmark State Employees plan documents, this benefit name is stated in the "other description" field in all of ABP5, if applicable for that particular benefit.

Dental services will be provided through contract(s) with PAHP(s).

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Illness/Injury Physician Services
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Athletic Trainers are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Physicians and Practitioners.

Benefit Provided: Specialty Physician Services
Source: Base Benchmark State Employees
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Physicians and Practitioners
NOTE: Iowa's Benchmark does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.

Benefit Provided: Home Health Services
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Not Covered: Custodial home care services and supplies, which help with daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. In order for care to be approved, must be approved by physician.

Remove

Benefit Provided: Chiropractors

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Surgery - Outpatient

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Second Surgical Opinion

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Allergy Testing and Injections

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Allergy Testing and Treatment

Benefit Provided: Chemotherapy - Outpatient

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: IV Infusion Services

Source: Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prescription Drugs

Benefit Provided:
Radiation Therapy - Outpatient

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Dialysis - Outpatient

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Covered as an inpatient in a hospital or in a Medicare approved dialysis center (outpatient).

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Remove

Benefit Provided: Anesthesia

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Ambulatory anesthesia is used for surgical procedures where the patient does not need to stay overnight in the hospital. The same anesthetics that are used in the operating room setting are used in the ambulatory setting, including general, regional and local anesthetics. Sedation anesthetics are also given in the ambulatory setting.

Remove

Benefit Provided: Urgent Care/Walkin Centers

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Used for sudden illness or injury and who need to see a doctor right away. Clinics are often called minor emergency, urgent care, or immediate care centers.

Remove

Benefit Provided: Access to Clinical Trials

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The state assures:
1. Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.
2. A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).
3. A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

General Condition of Coverage

Remove

Benefit Provided: Genetic Testing

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Genetic testing for purely informational purposes is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following are met: Appropriate candidate for a test under medically recognized standards, and outcome of the test is expected to determine a covered course of treatment or prevention.
NOTE: Iowa's Benchmark does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.

Remove

Benefit Provided: Dental Treatment for Accidental Injury

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Care must be completed within 6 months of .....

Scope Limit: See Other Information below for Covered and Not Covered services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Duration limit continued: injury. Treatment must have occurred while the member was covered under this group health plan.

Covered Services:
Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services

if: Based on a determination by a licensed dentist and treating physician, one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
Impacted teeth removal (surgical) as an inpatient or outpatient of a facility only when a medical condition exists (such as hemophilia) that requires hospitalization.
Facial bone fracture reduction.
Incisions of accessory sinus, mouth, salivary glands, or ducts.
Jaw dislocation manipulation.
Orthodontic services required for surgical management of cleft palate.
Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered:
General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or surgical management of cleft palate.
Injuries associated with or resulting from the act of chewing.
Maxillary or mandibular tooth implants (osseo integration).

Remove

Benefit Provided: Hospice Care - Outpatient

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Terminally ill patient and have a life expectancy of six months or less.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Terminally ill patients that have a life expectancy of six months or less. Services to provide comfort and support for persons in the last stages of a terminal illness and their families. In accordance with Section 2302 of the Affordable Care Act, individuals under age 21 (age 19 and 20 for purposes of this benchmark plan), must receive hospice care concurrently with curative care.

Remove

Benefit Provided: Inhalation Therapy

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: 60 visits per benefit year.

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Respiratory or breathing treatments to help restore or improve breathing function.

Benefit Provided:

Medical and Surgical Supplies

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medical supplies and devices such as dressing and casts, oxygen and equipment needed to administer oxygen.

Add

Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Room Services

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Emergency Services

Benefit Provided: Emergency Transportation-Ambulance & Air Ambulance

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: No other method of transportation is appropriate.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope limit continued: Services required to treat patient illness or injury are not available in the facility where the patient is currently receiving care if patient is an inpatient at a facility. Patient is transported to the nearest hospital or nursing facility in network with adequate facilities to treat condition. In emergency situation, patient may seek care at the nearest appropriate facility whether the facililty is in or out of network.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

Benefit Provided: General Inpatient Hospital Care

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Hospitals and Facilities

Remove

Benefit Provided: Inpatient Physician Services

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Inpatient Surgical Services

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hospitals and Facilities

Remove

Benefit Provided: Non-cosmetic Reconstructive Services

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Cosmetic services, supples or drugs are not covered unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any .....

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit Continued: complications resulting from noncovered cosmetic procedures.
Hospitals and Facilities

Remove

Benefit Provided: Transplant Organ and Tissue

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Covered - certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel.....

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope continued: Not covered - transport of living donor, expenses related to purchase of organ, services/ supplies related to mechanical or non-human organs, transplant services and supplies not listed in the Covered Services above. Any complications resulting from the Not Covered benefits listed would not be covered.
Transplants

Remove

Benefit Provided: Congenital abnormalities correction

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Reconstructive Surgery

Benefit Provided: Anesthesia - Inpatient

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Chemotherapy - Inpatient

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Radiation Therapy - Inpatient

Source: Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Breast Reconstruction

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reconstructive Surgery

Benefit Provided:
Hospice Care - Inpatient

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Terminally ill patient and have a life expectancy of six months or less.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
npatient services in a hospice facility. Services to provide comfort and support for persons in the last stages of a terminal illness and their families. In accordance with Section 2302 of the Affordable Care Act, individuals under age 21 (age 19 and 20 for purposes of this population), must receive hospice care concurrently with curative care.

Alternative Benefit Plan

Benefit Provided: Hospice Respite - Inpatient

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Limited to 15 days per lifetime for inpatient ...

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Duration continued: hospice respite care (can take place in a nursing home or hospital). Hospice respite care must be used in increments of not more than 5 days at a time.

Benefit Provided: Dialysis - Inpatient

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Covered as an inpatient in a hospital or in a Medicare approved dialysis center (outpatient)

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Maternity/Preg-Pre&Post Care-deliv,inpat nutrition

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Maternity care and newborn care not covered if mother is a surrogate mother. Would not cover a person for surrogate only purposes. If individual meets requirements for coverage under the new adult group she would be covered in that group.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

If length of stay is less than 48 or 96 hours, a follow-up postpartum home visit by an RN is covered.

Benefit Provided: Midwife Services

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physicians and Practitioners

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Remove

Benefit Provided: Mental Health/Behavioral Health Inpatient Treatmen

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Residential Facility services are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental Health Services
Iowa assures that mental health services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Remove

Benefit Provided: Mental Health/Behavioral Health Outpatient Treatme

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental Health Services
Iowa assures that mental health services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Remove

Benefit Provided: Substance Abuse Inpatient Treatment

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Residential Facility services are not covered

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Chemical Dependency Treatment

Iowa assures that substance abuse services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Remove

Benefit Provided:

Substance Abuse Outpatient Treatment

Source:

Base Benchmark State Employees

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Chemical Dependency Treatment

Iowa assures that substance abuse services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Add

■ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☒ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Iowa's ABP prescription drug benefit plan is the same (duplication of plan) as the approved Medicaid state plan for prescribed drugs.
NOTE: Some medications do require prior authorization, for example, to verify that a prescription drug is part of a specific treatment plan and is medically necessary.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Physical Therapy,Occupational Therapy,Speech Thera
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: Each therapy limited to 60 visits per year.
Scope Limit: Rehabilitative speech therapy services are covered ....

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit continued: when related to a specific illness, injury, or impairment and involve the mechanics of phonation, articulation or swallowing. Services must be provided by a licensed or certified speech pathologist. Speech therapy requires prior approval.

Not Covered: Physical therapy and occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization. Speech therapy not provided by licensed or certified speech therapist.

PT, OT and ST are considered rehab/hab services. The 60 visit limit is combined between habilitation and rehabilitation; however, the limit may be exceeded based on medical necessity.

Benefit Provided: Durable Medical Equipment
Source: Base Benchmark State Employees
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Home/Durable Medical Equipment
NOTE: Iowa's ABP does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.

Benefit Provided: Prosthetic Devices
Source: Base Benchmark State Employees
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Eyeglasses, air conduction hearing aids or examinations or fittings are not covered. Elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Cardiac Rehabilitation

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Pulmonary rehabilitation

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Skilled Nursing

Source:
Base Benchmark State Employees

Remove

Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

120 days per benefit year for services in .....

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Duration limit continued: a hospital or nursing facility.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Laboratory Services
Source: Base Benchmark State Employees
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: X-ray Services
Source: Base Benchmark State Employees
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Imaging - MRI, CT and PET
Source: Base Benchmark State Employees
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Some procedures require prior approval.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

X-ray Services

Benefit Provided: Sleep Studies

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Treatment for snoring not covered without diagnosis of sleep apnea.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Sleep Apnea Treatment

Benefit Provided: Diagnostic Genetic Tests

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Genetic molecular testing and related counseling are covered if appropriate candidate for a test under medically recognized standards (i.e. family background, past diagnosis etc.) and outcome of test is.....

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit Continued: expected to determine a covered course of treatment or prevention and is not merely informational.

Benefit Provided: Pathology

Source: Base Benchmark State Employees

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

X-ray and Laboratory Services

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Hearing Exam - Adult

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: One hearing exam per benefit year.

Scope Limit: Hearing aids are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hearing Services

Remove

Benefit Provided: Diabetes-med necessary equip & supplies

Source: Base Benchmark State Employees

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Insulin and Diabetic Supplies
NOTE: Iowa's Benchmark does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.

Remove

Benefit Provided: Prostate cancer screening

Source: Base Benchmark State Employees

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: one exam per year

Alternative Benefit Plan

Scope Limit:

Men age 50-64

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

X-ray and Laboratory Services

Benefit Provided:

Foot care

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Must be related to medical condition. Routine foot care is not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark State Employees

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Age 19 and 20 will receive EPSDT services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Precription Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Iowa's ABP prescription drug benefit plan is the same (duplication of plan) as the approved Medicaid state plan for prescribed drugs.

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Adult Vision

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Adult vision is covered in the base benchmark plan but it is an excepted benefit and therefore not an Essential Health Benefit.

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Newborn Child Coverage

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

This service is covered under the base benchmark plan but is not applicable for the new adult group population that is for ages 19-64. The adult member must enroll the newborn child for coverage.

Add

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Remove

Other 1937 Benefit Provided:
Dental Coverage

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Other

Amount Limit:
See "Other"

Duration Limit:
Based on each service - see below

Scope Limit:
See "Other"

Other:

In addition to the limitations listed below, dental services are limited to one thousand dollars ($1,000.00) per State Fiscal Year (July 1 - June 30). This limitation does not apply to the following services: preventive, diagnostic, emergency, anesthesia in conjunction with approved oral surgery codes or fabrication of dentures. The following limitations also apply to dental services but may be exceeded based on medical necessity. Enrollees under 21 years of age will be eligible for medically necessary dental services in accordance with federal EPSDT requirements.

Full Dental Benefits:
1. Preventive Services
a. Oral prophylaxis, including necessary scaling and polishing. Limitation: Once in a six month period except for persons who, because of physical or mental disability, need more frequent care.
b. Topical application of fluoride. Limitation: Once in a 90 day period (this does not include the use of fluoride prophylaxis paste as fluoride treatment).
c. Pit and fissure sealants. Limitation: Covered on first and second deciduous and permanent molars only for enrollees through 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

2. Diagnostic Services
a. Comprehensive evaluation. Limitation: maximum of 1 every 3 years per dentist.
b. Periodic evaluation. Limitation: maximum of 2 per 12 months, 6 months apart.
c. Full mouth radiograph survey consisting of a minimum of 14 periapical films and bitewing films. Limitation: Once in a 5 year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and disease. Full mouth radiograph surveys are not payable under the age of six.
d. Supplemental bitewing films. Limitation: Once in a 12-month period.
e. Single periapical films, intraoral radiograph, occlusal, extraoral radiograph, posterior-anterior and lateral skull and facial bone radiograph, survey film, temporomandibular joint radiograph, and cephalometric film when medically necessary.

3. Restorative Services
a. Treatment of dental caries in those areas which require immediate attention. Limitation: Restoration of incipient or nonactive carious lesions are not covered.
b. Amalgam alloy and composite resin-type filling materials. Limitation: Once for the same restoration in a two-year period. An amalgam restoration is covered following a sedative filling in the same tooth only if the sedative filling was placed more than 30 days previously.
c. Stainless steel crowns when a more conservative procedure would not be serviceable. Limitation: Stainless steel crowns with a resin window are limited to anterior teeth.
d. Laboratory fabricated crowns. Prior Authorization is required. Limitation: Noble metals are limited to individuals who are allergic to other restorative materials.

e. Cast post and core, post and composite or amalgam in addition to a crown. Limitation: Covered if a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

4. Periodontal Services - Full mouth debridement. Limitation: Once every 24 months and is not allowed on the same date of service when prophylaxis or other periodontal services are provided. Periodontal treatment procedures require prior authorization.

5. Endodontic Services - Covered when there is fair to good prognosis for maintaining the tooth. Endodontic retreatment requires prior authorization.

6. Orthodontic Services - Covered for a severe handicapping malocclusion. Prior authorization is required. Limitation: not covered for enrollees 21 years of age and over.

7. Prosthetic Services
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. Limitation: 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 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. Limitation: 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 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.

8. Implants.
Covered when a conventional denture cannot be used due to missing significant oral structures as a result of cancer, traumatic injuries, or developmental defects such as cleft palate. Prior authorization is required.

9. Treatment in a hospital.
Covered only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

Basic Dental Benefits:

As provided under the authority of section 1115 Iowa Dental Wellness Plan waiver approved on July 27, 2017 and represent 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: 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 the "Dentures" benefit.

Other 1937 Benefit Provided: Adult Vision

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: One routine vision exam per benefit year

Scope Limit: Not covered - Surgery to correct a refractive error,eyeglasses or contact lenses including charges related to their fitting, prescribing of corrective lenses, eye examinations for the fitting of eye wear.

Other: No prior authorization is required for exam.

Other 1937 Benefit Provided: Dentures

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Other

Amount Limit:

See "Other"

Duration Limit:

Based on each service - see "Other"

Scope Limit:

See "Other"

Other:

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. Limitation: 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 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. Limitation: 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 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.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

Alternative Benefit Plan

- ☐ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- ☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.
- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☐ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

State Name: Iowa | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: IA - 22 - 0006 | OMB Expiration date: 10/31/2014

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
  - ☒ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☒ Prepaid Ambulatory Health Plans (PAHP).
  - ☐ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

Effective April 1, 2016, Iowa Wellness Plan members will be required to enroll with a managed care organization (MCO) as described in the State's High Quality Healthcare Initiative 1915(b) waiver.

The State engaged the public in development of the Initiative through a variety of strategies. On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative (http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization). Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. On March 26, 2015, the DHS released an amended version of the RFP which incorporated changes based on stakeholder feedback. The public also had the opportunity to comment on the waiver amendments associated with the Initiative through a public notice and comment process. Tribal notice was also provided in accordance with the State Plan requirements.

Statewide MCO enrollment in the Initiative will be effective April 1, 2016. The State will begin notifying patients and providers in fall 2015, at which time the Enrollment Broker will begin taking MCO selections and providing choice counseling to assist enrollees. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) deal the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO

options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause. Further, the State will ensure continuity of care for transitioning participants by requiring that MCOs honor existing authorizations for covered benefits for a minimum of ninety calendar days, without regard to whether such services are being provided by contract or non-contract providers.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ◉ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Feb 23, 2016

Describe program below:

Individuals are enrolled in managed care via the High Quality Healthcare Initiative 1915(b) waiver authority. All included benefits, eligible populations and program descriptions are referenced in the waiver.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: May 1, 2014

Describe program below:

Dental services will be provided through contract(s) with PAHP(s). The PAHP(s) have developed a provider panel sufficient to meet the needs of the population to be enrolled. All dental services allowed under the enabling legislation and subsequent 1115

waiver that allows eligibility will be provided through the PAHP(s).

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- (●) Traditional state-managed fee-for-service
- ( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

As outlined in the High Quality Healthcare Initiative 1915(b) waiver, individuals excluded from managed care enrollment, and American Indian/Alaskan Native enrollees who opt not to enroll with a managed care organization are enrolled in fee-for-service. Traditional fee-for-service reimbursement methodologies will apply as outlined in the State Plan for services delivered to fee-for-service enrollees.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

V.20140417

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums	ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The state assures that employer sponsored insurance (ESI) coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package in the alternative benefits plan to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **No**

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Alternative Benefit Plan

Attachment 3.1-L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

General Assurances	ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

Attachment 3.1-■ L

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20130807