AGREEMENT
BETWEEN
IOWA DEPARTMENT OF HUMAN SERVICES
AND
AMERIGROUP IOWA, INC.

THIS AGREEMENT is made and entered into by the Iowa Department of Human Services (the "Department"), an administrative agency within the executive department of the State of Iowa, having its principal office at 1305 E. Walnut St., Des Moines, IA, 50319-0114, and Amerigroup Iowa, Inc. ("MA Health Plan"), a corporation organized under the laws of the State of Iowa and having a principal place of business at 4800 Westown Parkway, Suite 200, West Des Moines, Iowa 50266.

Article I. BACKGROUND

The MA Health Plan has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to provide an MA-PD Plan ("MA Agreement"). Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the MA Health Plan to enter into an agreement with the Department to provide or arrange for benefits to be provided, for which a dually eligible individual is entitled to receive. As a result, the MA Health Plan and the Department wish to enter into this agreement to outline each party's obligations to provide or arrange for benefits for Dual Eligible Members.

In consideration of the premises and the mutual promises and undertakings herein contained, the parties agree to the following terms and conditions.

Article II. DEFINITIONS

Affiliate means with respect to any person or entity, any other person or entity which directly or indirectly controls, is controlled by or is under common control with such person or entity.

Cost Sharing Obligations mean those financial payment obligations incurred by the Department in satisfaction of the Deductibles, Coinsurance, and Co-payments for the Medicare Part A and Part B services with respect to Dual Eligible Members. For purposes of this Agreement, Cost Sharing Obligations do not include: (1) Medicare premiums that the Department is required to pay under the State Plan on behalf of Dual Eligible Members, or (2) any other services that are covered solely by the Iowa Medicaid Program ("Medicaid").

Dual Eligible means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the Department has a responsibility for payment of Cost Sharing Obligations under the State Plan. For purposes of this Agreement, Dual Eligibles are limited to the following categories of recipients: Full Benefit Dual Eligible, QMB Only, QMB Plus, and SLMB Plus**.**

Dual Eligible Member means a Dual Eligible or Other Dual Eligible who is eligible to participate in, and voluntarily enrolled in, the MA Health Plan's MA-PD Plan.

Dual Special Needs Plan means a MA-PD Plan that has received CMS approval to offer an MA-PD Plan that specifically target certain categories of Dual Eligible and Other Dual Eligible individuals.

Full Benefit Dual Eligible (FBDE aka Medicaid only): An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups such as medically needy, or special income levels for institutionalized, or home and

community-based waivers. FBDEs are eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and co-payments (except for Medicare Part D).

MA Agreement means the Medicare Advantage Agreement between the MA Health Plan and CMS to provide Medicare Part C and other health plan services to the MA Health Plan's members.

MA-PD Plan means the CMS approved Medicare Advantage plan sponsored, issued, or administered by the MA Health Plan as defined at 42 C.F.R. § 423.4 and includes, but is not limited to, institutional and Dual-Eligible Special Needs Plans as defined in the Medicare Advantage Rules.

Other Dual Eligible means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the Department does not have a responsibility for payment of Cost Sharing Obligations under the State Plan. For purposes of this Agreement, Other Dual Eligibles are limited to the following categories of recipients: SLMB, QDWI, and QI**.**

Qualified Medicare Beneficiary (QMB) means an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed twice the maximum allowed by the Supplemental Security Income (SSI) program for subsidy eligibility. A QMB is eligible for Medicaid payment of Medicare premiums, deductibles, coinsurance, and co-payments (except for Medicare Part D) ("QMB Medicaid Benefits"). Categories of QMBs covered by this Agreement are:

- **QMB Only** – QMBs who do not qualify for any additional QMB Medicaid benefits.
- **QMB Plus**– QMBs who also meet the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medicaid Benefits, plus all benefits under the State Plan for fully eligible Medicaid recipients.

Qualified Disabled and Working Individual (QDWI) means an individual who is under 65 years of age, has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI resource limit. The individual may not be otherwise eligible for Medicaid. QDWIs are eligible only for Medicaid payment of the Part A premium.

Qualifying Individual (QI) means an individual entitled to Medicare Part A, has income at least 120% FPL but less than 135% FPL, and resources that do not exceed the maximum allowed by the SSI program for subsidy eligibility, and not otherwise eligible for Medicaid benefits. QI individuals are eligible for Medicaid payment of Medicare Part B premium.

Specified Low-Income Medicare Beneficiary (SLMB): An individual entitled to Medicare Part A, has income that exceeds 100% FPL but less than 120% FPL, and resources do not exceed the maximum allowed by the SSI program for subsidy eligibility. SLMB individuals are eligible for Medicaid payment of Medicare Part B premium. Categories of SLMBs covered by this Agreement are:

- **SLMB** Only – SLMBs who do not qualify for any additional Medicaid benefits.
- **SLMB Plus** – SLMBs who also meet the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

State Plan means the State of Iowa's plan for the Medical Assistance Program as submitted by the Department and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.

Subcontract means an agreement between the MA Health Plan and a third party under which the third party agrees to accept payment for providing health care services for the MA Health Plan's members.

Subcontractor means a third party with which the MA Health Plan has a subcontract.

Article III. MA HEALTH PLAN'S OBLIGATIONS

Section 3.01 Service Area.

(a) The service area is the geographic area in which enrollees or potential enrollees reside and for whom the MA Health Plan is approved to provide services by CMS. The service area covered by this MA Health Plan identified on Appendix A. The MA Health Plan will also identify the service area of the MA-PD Plans according to either counties or zip codes on Appendix A.

(b) The MA Health Plan must notify the department in writing within 15 business days from the time the MA Health Plan decides to change the service area, whether it is an addition or deletion. Further, the MA Health Plan shall provide a copy of CMS' approval of such change within 15 business days of the receipt of CMS approval and the MA Health Plan shall provide the Department with a revised Appendix A.

Section 3.02 Enrollment

(a) The MA Health Plan will verify prior to enrollment of a potential Dual Eligible Member, the individual's Medicare eligibility. Unless a Dual Eligible or Other Dual Eligible is otherwise excluded under federal Medicare Advantage plan rules, the MA Health Plan will accept all Dual Eligible or Other Dual Eligible individuals who select the MA Health Plan's MA-PD Plan without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of such discrimination.

(b) The MA Health Plan may enroll those categories of dual eligible individuals indicated on Appendix A.

(c) The MA Health Plan will verify prior to enrollment of a potential Dual Eligible Member, the individual's Medicaid eligibility. The MA Health Plan may also conduct ongoing eligibility verification of Dual Eligible Members. The Department will provide MA Health Plan with access to the state's eligibility system consistent with Section 4.01 so that the MA Health Plan can verify a potential Dual Eligible Member or Dual Eligible Member's current Medicaid status.

(d) The MA Health Plan may choose to use a Subcontractor to conduct eligibility verification outlined in this Section so long as the Subcontractor has met the Department's requirements for access to their state eligibility database.

Section 3.03 Benefits and Coordination.

(a) The MA Health Plan will provide the covered benefits under the MA-PD Plan to all Dual Eligible Members who are qualified to receive such services under the eligibility requirements of the MA-PD Plan.

(b) The MA Health Plan is not responsible for providing or reimbursing any Medicaid benefits under this Agreement. This provision does not limit or otherwise restrict the MA Health Plan's obligation to arrange for or provide care coordination as outlined in Section 3.03(d). The MA Health Plan shall maintain current knowledge and familiarity of Iowa's Medicaid benefits through ongoing reviews of Iowa laws, rules, policies, and further guidance as posted on the IME website. The MA Health Plan shall timely coordinate Medicaid benefits for its enrolled Dual Eligible Members as described in Appendix B of this Agreement.

(c) The MA Health Plan will identify for Dual Eligible Members in the MA Health Plan's Summary of Benefits those benefits the member may be eligible for under the State Plan that are not covered services under the Member's MA Health Plan and coordinate access to such benefits as outlined in Section 3.03(d). To facilitate this process, the Department will provide the MA Health Plan with the State Plan benefits as outlined in Section 4.02. The MA Health Plan will provide a copy of the Summary of Benefits to the Department thirty (30) days after the MA Health Plan receive notice from CMS that the Summary of Benefits has been approved.

(d) The MA Health Plan is responsible for coordinating the delivery of all benefits covered by both Medicare and the Iowa Medicaid Program, including when Medicaid benefits are delivered via Fee-For-Service and/or Iowa Health Link program. The MA Health Plan is responsible for coordinating the enrollee's Medicare and Medicaid benefits, including, but not limited to discharge planning, disease management, and care management. Consistent with the MA Health Plan's Model of Care, coordination of care for Dual Eligible Members by the MA Health Plan will include the following:

i. Identifying for Dual Eligible Members of the Special Needs Plan in the MA Health Plan's Summary of Benefit those benefits the member may be eligible for under the State Plan that are not covered services under the Member's Dual Special Needs Plan to the extent that the Department has provided State Plan benefit information outlined in Section 4.02 of this Agreement.

ii. Providing Dual Eligible Members with information (including contact information) to access Medicaid benefits upon the Dual Eligible Member's request or as identified by the case coordinator or other MA Health Plan staff.

iii. Coordinate access to Medicaid covered services upon the Dual Eligible Member's request or as identified by the MA Health's Plan's care coordinator. Such coordination may include identification and referrals to needed services, assistance with Medicaid appeals and grievances, assistance in care planning, and assistance in obtaining appointments for needed services.

iv. Identifying Medicaid participating providers for the Dual Eligible Members to the extent the Department has provided such information as outlined in Section 4.02 of this Agreement.

v. Making information available to MA Health Plan's network providers regarding Medicaid so that they may assist Dual Eligible Members to receive needed services not covered by Medicare.

vi. Providing information to MA Health Plan's network providers about coordination of Medicaid and Medicare benefits for Dual Eligible Members.

(e) The Department will provide contact and resource information, to the extent available, for the State Plan to the MA Dual SNP that allows the MA Dual SNP to access information regarding the State Plan, including the State Plan's Medicaid benefits, Medicaid providers, State Plan's case managers, and the State Plan's waiver program.

(f) For all full dual eligible members enrolled in the Iowa Health Link program for Medicaid, the MA Health Plan shall provide timely notifications of all admissions, discharge and/or transfers to a hospital and skilled nursing facility (SNF) to the enrollee's Iowa Health Link – Managed Care Organization as applicable to the member.

i. Timely notification is defined as within 48 hours of the time upon which the MA Health Plan becomes aware that a full dual eligible member enrolled in the Iowa Health link program has experience a hospital or SNF admission, discharge and /or transfer.
ii. To ensure proper and timely notification the MA Health link Plan and the Managed Care Organizations will exchange files pursuant to a method and frequency agreed upon both parties.
iii. To verify eligibility of full dual eligible members enrolled in the Iowa Health link program, the MA Health Plan will review a file shared by the Department via SFTP on a monthly basis.

(g) If the MA Health Plan delegates responsibility for notification to its contracted hospitals and SNFs:

a. The MA Health plan will require its contracted hospitals and SNFs to meet the notification requirements on admissions as specified in this agreement. The MA Health Plan retains responsibility for compliance with the notification requirements in this agreement.

Section 3.04 Cost-Sharing Protections

(a) Neither the MA Health Plan nor any of its Subcontractors may collect any additional payment for Cost Sharing Obligations from a Dual Eligible Member other than what is allowed by federal or state law.

(b) The MA Health Plan will not impose or permit its Subcontractors to collect cost sharing on a Dual Eligible Members that exceeds the cost sharing permitted with respect to the Dual Eligible Member under Medicaid if the Dual Eligible Member were not enrolled in a MA Health Plan. The MA Health Plan must notify its Subcontractors (via a provider manual, provider bulletin, or other contractual document) that they may not seek additional payments for Cost Sharing Obligations from Dual Eligible Members for health care services rendered to Dual Eligible Members other than what is allowed by federal or state law. The MA Health Plan must notify its Subcontractors that they must seek payment from the Department for such Cost Sharing Obligations or accept payment from the MA Health Plan as a payment in full. The MA Health Plan must provide the Department contact identified in Section 7.08 with a copy of such written notice.

(c) Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments. A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to the MA Health Plan for Medicare Part A or Part B cost sharing amounts. The MA Health Plan provider agreements shall specify that a contracted Medicare provider agree to accept the MA Health Plan's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill the Department as applicable for any additional Medicare payments that may be reimbursed by Medicaid. Dual Eligible Members shall be responsible for any applicable Medicaid copayments

Section 3.05 Third Party Liability & Coordination of Benefits.

(a) The Department is responsible for adjudicating the Cost Share Obligations under the State Plan.

(b) The MA Health Plan will adjudicate and pay claims in accordance with Medicare rules and regulations and provide Evidence of Payment information to providers, which identifies coordination amounts for their claim submission to the State Plan.

(c) Pursuant to the State Plan, the Department will remain financially responsible for Cost-Sharing Obligations and Medicaid Benefits for Dual Eligible who are Member of MA Health Plan's SNP(s). The Department may have financial responsibility for Medicare Part A and/or Part B premiums for Dual Eligible. The Department is not responsible for payment of Medicare Advantage premiums for mandatory or optional Supplement Benefits, unless specifically prescribed in the State Plan.

(d) When dual eligible members change MA Health Plan, both MA Health Plans have the responsibility to work together to coordinate benefits including continuity of care regarding prior authorizations and sharing medical and case management records once member permission has been obtained.

(e) The MA Health Plan shall coordinate benefits with the MCO to which the dual eligible member belongs and this must be reflected in the MA Health Plan care coordination policies.

Article IV. DEPARTMENT OBLIGATIONS

Section 4.01 Eligibility Verification.

(a) The Department agrees to provide the MA Health Plan or its Subcontractors with access to the Eligibility and Verification Information System ("ELVS") that permits the MA Health Plan to verify eligibility of enrolled and potential Dual Eligible Members. The Department will assist the MA Health Plan with information to allow the MA Health Plan to identify the specific categories of eligibility of Dual Eligibles. Information obtained by the MA Health Plan from the Department's eligibility verification system shall not be used by the MA Health Plan for marketing purposes.

(b) Any D-SNPs affiliated with a companion Medicaid managed care plan can verify ongoing Medicaid eligibility through the enrollment and disenrollment process established for the Iowa Health Link program.

(c) The MA Health Plan shall verify Medicare eligibility of individual members when requested by the Department.

Section 4.02 Sharing of Information.

(a) The MA Health Plan has to obtain certain pieces of information from the Department to comply with CMS requirements for Dual Special Needs Plans. In particular (i) the Department will provide the MA Health Plan with access to an electronic data file of participating Medicaid providers on at least a monthly basis, and (ii) the Department will provide the MA Health Plan with a list of services and products for which Dual Eligible and Other Dual Eligible individuals are eligible for under the State Plan on an annual basis unless significant changes occur during the middle of the year or by March 31 of the preceding

year if CMS requires the MA-PD Plan to provide such information in the MA-PD Plan's Summary of Benefits.

(b) The Department will provide the MA Health Plan with an electronic data file containing Medicaid participating providers in a mutually-agreed upon format on a monthly basis. Any D-SNPs affiliated with a companion Medicaid managed care plan can obtain the file from the affiliated Managed Care Organization. Once the Department provides an electronic data file list of enrolled Medicaid providers, the MA Health Plan will identify in its provider directory those health care providers that are participating in both the State Plan and the MA Health Plan's network for Dual Eligible Members who are enrolled in a Dual Special Needs Plan in the Dual Special Needs Plan's provider directory.

Article V. TERM, TERMINATION

Section 5.01 Term.

The term of this Agreement shall be January 1, 2021 through December 31, 2025, unless terminated earlier in accordance with Section 5.02.

Section 5.02 Termination.

(a) This Agreement may be terminated by mutual agreement of the parties. The Agreement may also be terminated without cause by either party by giving the other party 90 days' notice. Such agreement must be in writing. The effective date of termination is dependent on any pertinent CMS requirements, including CMS requirements related to notification of Dual Eligible Members.

(b) The MA Health Plan may terminate this Agreement by notifying the Department that it is notified by CMS that all of the MA Health Plan will not be permitted to continue offering the MA-PD plans identified on Appendix A. The termination will be effective on the date specified in the MA Health Plan's notice of termination.

(c) In the event of termination pursuant to this Section, the Department will continue to provide the MA Health Plan access to the state's eligibility database for purposes of confirming Medicaid eligibility for six (6) months to allow the MA Health Plan to continue to confirm eligibility of Dual Eligible Members.

Article VI. DISPUTE RESOLUTION

Section 6.01 General Agreement of the Parties.

The parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the parties employ all reasonable and informal means to resolve any dispute under this Agreement. The parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

Section 6.02 Duty to Negotiate in Good Faith.

Any dispute that in the judgment of any party to this Agreement may materially or substantially affect the performance of this Agreement will be reduced to writing and delivered to the other party. The parties must then negotiate in good faith and use reasonable efforts to resolve such dispute and the parties

shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by agreement between the parties shall be reduced to writing and delivered to all parties within ten (10) business days.

Section 6.03 *Reserved*

Article VII. MISCELLANEOUS PROVISIONS

Section 7.01 *Entire Agreement.*

This Agreement contains the entire understanding between the parties hereto with respect to the subject matter of this Agreement and supersedes any prior understandings, agreements or representations, written or oral, relating to the subject matter of this Agreement.

Section 7.02 *Signatures & Counterparts.*

This Agreement will be effective only when signed by both parties. This Agreement may be executed in separate counterparts, each of which will be an original and all of which taken together will constitute one and the same agreement, and a party hereto may execute this Agreement by signing any such counterpart.

Section 7.03 *Non-Debarment.*

The MA Health Plan represents that neither it nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal health care program.

Section 7.04 *Severability.*

Whenever possible, each provision of this Agreement will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this Agreement is held to be invalid, illegal or unenforceable under any applicable law or rule, the validity, legality and enforceability of the other provisions of this Agreement will not be affected or impaired thereby.

Section 7.05 *Successors & Assigns.*

This Agreement will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives and, to the extent permitted by Section 7.06, successors and assigns.

Section 7.06 *Assignment.*

This Agreement and the rights and obligations of the parties under this Agreement will be assignable, in whole or in part, by the MA Health Plan with the prior written consent of the Department's point of contact identified in Section 7.08.

Section 7.07 *Modification, Amendment, or Waiver.*

No provision of this Agreement may be modified, amended, or waived except by a written signed by parties to this Agreement. No course of dealing between the parties will modify, amend, or waive any provision of this Agreement or any rights or obligations of any party under or by reason of this Agreement.

Section 7.08 Notices.

All notices, consents, requests, instructions, approvals or other communications provided for herein will be in writing and delivered by personal delivery, overnight courier, mail, or electronic facsimile addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

State of Iowa	**Amerigroup Iowa, Inc.**
Iowa Department of Human Services	**Blythe Agtarap**
1305 E. Walnut Street	**4553 La Tienda Drive**
Des Moines, IA 50319,	**Thousand Oaks, CA 91362**
	Mail-stop CAT102-C001

A party may change the contact information set forth above by giving written notice to the other party.

Section 7.09 Headings.

The headings and any table of contents contained in this Agreement are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.

Section 7.10 Compliance with Federal and State Law.

The parties agree to comply with all relevant federal and state laws, including but not limited to the following: the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS; 42 CFR Part 422; Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.); Sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 USC §§ 793 and 794); Title IX of the Education Amendments of 1972, as amended (20 USC § 1681 et seq.); Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (41 USC § 9849); the Americans with Disabilities Act (42 USC § 12101 et seq); and the Age Discrimination Act of 1975, as amended (42 USC § 6101 et seq.).

Section 7.11 Governing Law & Venue.

The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Agreement without regard to the conflicts of laws provisions of Iowa law. Any and all litigation commenced in connection with this Contract shall be brought and maintained solely in Polk County District Court for the State of Iowa, Des Moines, Iowa, or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa, wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Agency or the State of Iowa.

Section 7.12 *No Third-party Beneficiaries.*

Nothing in this Agreement, express or implied, is intended to confer upon any other person any rights, remedies, obligations or liabilities of any nature whatsoever.

Section 7.13 *Publicity.*

Except as otherwise required by this Agreement of by law, no party will issue or cause to be issued any press release or make or cause to be made any other public statement as to this Agreement or the relationship of the parties, without providing notice to the other party of the contents and manner of presentation and publication thereof. Either party shall have the ability to specifically request that prior consent shall be provided to release information publicly and the parties shall negotiate in good faith regarding whether such request can be accommodated.

Section 7.14 *No Waiver.*

No delay on the part of either party in exercising any right under this Agreement will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party will constitute a waiver of any other right or breach by the other party.

[Remainder of this section intentionally left blank. Signature page follows.]

IN WITNESS WHEREOF, authorized representatives of the parties execute this Agreement to be effective as of the Effective date:

State of Iowa
Iowa Department of Health and Human Services

By: Michael Randol

Printed Name: Michael Randol

Title: Medicaid Director

Date: 06/10/2020

MA Health Plan – Amerigroup Iowa, Inc.

By: M Esq

Printed Name: Martin Esquivel

Title: VP, Medicare Product Management

Date: 06/08/2020

APPENDIX A

MA-PD PLANS
APPLICABLE SERVICE AREAS AND
DUAL ELIGIBLE AND OTHER DUAL ELIGIBLE CATEGORIES

MA-PD PLAN NAME	CONTRACT NUMBER	SERVICE AREA	SPECIAL NEEDS PLAN (Y/N)	APPLICABLE CATEGORY OF DUAL ELIGIBLE OR OTHER DUAL ELIGIBLE
Amerigroup Iowa, Inc. Amerivantage Dual Coordination (HMO D-SNP)	H0907-001	Benton, Cedar, Cerro Gordo, Clarke, Grundy, Guthrie, Henry, Jackson, Jasper, Jefferson, Johnson, Linn, Lucas, Madison, Polk, Poweshiek, Tama, Union, Warren, Washington, Winneshiek	Y	FBDE, QMB PLUS, QMB only and SLMB PLUS

APPENDIX B

MEDICAID COVERED BENEFITS

The MA Health Plan shall provide the covered benefits as described in Section 3.03 (a) of the Agreement. Medicaid covered services are provided by the State and are outlined in Iowa Admin. Code r. 441-78, within the State Plan, and all CMS approved waivers.

Table 1: Full Medicaid Covered Benefits & Limitations

SERVICE	LIMITATIONS
1915(C) SERVICES	1915(c) waiver services as authorized in accordance with the federal waiver.[1]
1915(I) HABILITATION SERVICES	1915(i) state plan services as authorized in accordance with the federal state plan amendment.[2]
ABORTIONS	Abortions may only be authorized in the following situations: • If the pregnancy is the result of an act of rape or incest; or • In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. No other abortions, regardless of funding, can be provided as a benefit under this Contract.
ALLERGY TESTING AND INJECTIONS	Medicaid plans must use utilization management guidelines established[3].
ANESTHESIA	Medicaid plans must use utilization management guidelines established.
B3 SERVICES	Medicaid plans must use utilization management guidelines established and approved by the Agency. The ASAM Criteria is used as the utilization management guidelines for substance use disorder residential treatment.
BARIATRIC SURGERY	Medicaid plans must use utilization management guidelines established.
BHIS (INCLUDING ABA)	Medicaid plans must use utilization management guidelines established.
BREAST RECONSTRUCTION	Medicaid plans must use utilization management guidelines established.
BREAST REDUCTION	Medicaid plans must use utilization management guidelines established.

CARDIAC REHABILITATION	Medicaid plans must use utilization management guidelines established.
CHEMOTHERAPY	Medicaid plans must use utilization management guidelines established.
CHIROPRACTIC CARE (THERAPEUTIC ADJUSTIVE MANIPULATION)	• X-ray- payment for documenting x-rays is limited to one per condition. No payment shall be made for subsequent x-rays. • Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. There are three categories based off the patient's condition / diagnosis. A diagnosis or combination of diagnoses within category i generally required short-term treatment of 12 per 12-month period. A diagnosis or combination of diagnoses with category ii generally required moderate-term treatment of 18 per 12-month period. A diagnosis or combination of diagnoses within category iii generally required long-term treatment of 24 per 12-month period. For diagnostic combinations between categories, 28 treatments are generally required per 12-month period.
COLORECTAL CANCER SCREENING	Medicaid plans must use utilization management guidelines established.
CONGENITAL ABNORMALITIES CORRECTION	Medicaid plans must use utilization management guidelines established.
DAIBETIES EQUIP AND SUPPLIES	Medicaid plans must use utilization management guidelines established.
DIAGNOSTIC GENGETIC TESTING	Medicaid plans must use utilization management guidelines established.
DIALYSIS	Medicaid plans must use utilization management guidelines established.
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	• Medical supplies are not to exceed a three-month supply. Diabetic supplies are covered as follows: blood glucose test or reagent strips 6 units per month (1 unit equals 50 strips); urine glucose test strips 3 units per month (1 unit equals 100 strips), lancets 4 units per month (1 unit equals 100 lancets), and needles 500 units per month (1 unit equals 1 needle). Reusable insulin pens are allowed once every six months. Diapers and disposable under pads are covered and can be provided in a 90-day period. Diaper/brief 1,80 per 90-day supply, liner/shield/guard/pad 450 per 90-day supply, pull-on 450 per 90-day supply, disposable under pads 600 per 90-day supply, reusable under pads 48- per 12 months. Maximum units can very when combinations of incontinence products are used. Hearing aid batteries are covered up to 30 batteries per aid in a 90-day period. Ostomy supplies and accessories are covered one unit per day of regular wear or three units per month of extended wear are allowed. Services are limited to members in a medical facility. No payment is made to

	medical suppliers for medical supplies or durable medical equipment for members receiving inpatient or outpatient care in a hospital. • No payment is made for medical supplies or durable medical equipment for members for whom the facility is receiving skilled nursing care payment, except for orthotic and prosthetic services, orthopedic shoes, and therapeutic shoes for diabetics. • No payment is made for durable medical equipment or supplies for members • In an intermediate care facility for intellectual disability or a facility receiving • Nursing facility payments, except for the following: • Catheter (indwelling foley) • Colostomy and ileostomy appliances • Colostomy and ileostomy care dressings, liquid adhesive, and adhesive • Tape • Diabetic supplies (disposable or retractable needles and syringes, • Test-tape, clinitest tablets, and clinistix) • Disposable catheterization trays or sets (sterile) • Disposable bladder irrigation trays or sets (sterile) • Disposable saline enemas (sodium phosphate type, for example) • Hearing aid batteries • Orthotic and prosthetic services, including augmentative communication • Devices • Orthopedic shoes • Repair of member-owned equipment • Oxygen services: Oxygen services for residents in an ICF/ID are included in the per diem and are not payable separately. • Assistive Technology.
EMERGENCY ROOM SERVICES	Medicaid plans must use utilization management guidelines established.
EPSDT	Medicaid plans must use utilization management guidelines established.
FAMILY PLANNING	Medicaid plans must use utilization management guidelines established.
FOOT CARE	Medicaid plans must use utilization management guidelines established.
GENERAL INPATIENT HOSPITAL CARE	Medicaid plans must use utilization management guidelines established.
GENETIC COUNSELING	Medicaid plans must use utilization management guidelines established.
GYNOCOLOGICAL EXAMS	Medicaid plans must use utilization management guidelines established.

HEARING AIDS	Medicaid plans must use utilization management guidelines established.
HEARING EXAMS	• Prior authorization is required for replacement of a hearing aid less than 4 years old, except when member is a child under 21 years of age.
HOME HEALTH	• Skilled nursing is limited to five visits per week. • Home health aide is limited to visits that do not exceed 28 hours per week • Occupational therapy is limited to physician-authorized visits within guidelines for restorative, maintenance or trial therapy • Physical therapy is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy • Speech pathology is limited to physician-authorized visits within guidelines defined for restorative, maintenance or trial therapy
HOSPICE	Medicaid plans must use utilization management guidelines established.
ICF/ID	Must meet level of care.
IMAGING/DIAGNOSTICS (MRI, CT, PET)	Medicaid plans must use utilization management guidelines established.
IMMUNIZATIONS	Medicaid plans must use utilization management guidelines established.
INFERTILITY DIAGNOSIS AND TREATMENT	Medicaid plans must use utilization management guidelines established.
INHALATION THERAPY	Medicaid plans must use utilization management guidelines established.
INPATIENT PHYSICIAN SERVICES	Medicaid plans must use utilization management guidelines established.
INPATIENT SURGICAL SERVICES	Medicaid plans must use utilization management guidelines established.
IV INFUSION SERVICES	Medicaid plans must use utilization management guidelines established.
LAB TESTS	Medicaid plans must use utilization management guidelines established.
MATERNITY AND PREGNANCY SERVICES	Medicaid plans must use utilization management guidelines established.
MEDICAL TRANSPORTATION	Medicaid plans must use utilization management guidelines established.
MENTAL HEALTH/BEHAVIORAL HEALTH OUTPATIENT TREATMENT	Medicaid plans must use utilization management guidelines established.
MENTAL/BEHAVIORAL HEALTH INPATIENT TREATMENT	Medicaid plans must use utilization management guidelines established.

MIDWIFE SERVICES	Medicaid plans must use utilization management guidelines established.
NEMT	Medicaid plans must use utilization management guidelines established.
NEWBORN CHILD COVERAGE	Medicaid plans must use utilization management guidelines established.
NON-COSMETIC RECONSTRUCTIVE SURGERY	Medicaid plans must use utilization management guidelines established.
NURSING FACILITY	Must meet level of care.
NURSING SERVICES	• Private duty nursing and personal care services are covered as a benefit under EPSDT as provided through a home health agency for up to 16 hours per day.
NUTRITIONAL COUNELING	Medicaid plans must use utilization management guidelines established.
OCCUPATIONAL THERAPY	• Total Medicaid payment for services provided by an independently practicing occupational therapist shall not exceed the therapy cap as disclosed by the centers of Medicare and Medicaid services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. This new law extends the exceptions process for outpatient therapy caps through March 31, 2015. The statutory Medicare Part B outpatient therapy cap for occupational therapy (OT) is $1,920.
ORTHOTICS	• Payment for orthopedic shoes and inserts and therapeutic shoes for members with diabetes are limited as follows: only two pairs of depth shoes per member are allowed in a 12-month period, three pairs of inserts in addition to the non-customized removable inserts provided with depth shoes are allowed in a 12-month period, only two pairs of custom-molded shoes per member are allowed in a 12-month period, two additional pair of inserts for custom-molded shoes are allow in in a 12-month period.
OUTPATIENT SURGERY	Medicaid plans must use utilization management guidelines established.
PATHOLOGY	Medicaid plans must use utilization management guidelines established.
PHARMACY	• Prior authorization is required as specified in the Preferred Drug List http://www.iowamedicaidpdl.com/ • Reimbursement is only for drugs marketed by manufacturers with a signed rebate agreement. • Coverage of drugs in the following categories is excluded: (1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act. (2) Drugs used for anorexia, weight gain, or weight loss. (3) Drugs used for cosmetic purposes or hair growth. (4) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that

	associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee. (5) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)). (6) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan. (7) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility (8) Drugs used for sexual or erectile dysfunction (9) Drugs for symptomatic relief of cough and colds, except listed nonprescription drugs • Only certain nonprescription (OTC) drugs and non-drugs are covered as listed in 441 Iowa Administrative Code § 78.2(5) and at http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/nonprescription-drugs/2011-11-09/otclistbythercategory20111101.pdf And http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/2014-12-12/Non-Drug%20Product%20List%20Effective%201-1-15.pdf. • Quantity: up to 31 day supply at a time except contraceptives at 90 day; otcs at minimum quantity of 100 units per prescription or currently available consumer package. Some drugs are limited to an initial 15 day supply, list at: http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/15-days-supply-list-effective-01-01-15.pdf • Monthly quantity limits by drug list at: http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/quantity-limits/2014-11-24/quantity-limits-list-1-1-15.pdf • Reimbursement at lower of Iowa AAC (WAC if no AAC), FUL or U&C.
PHYSICAL THERAPY	• Total Medicaid payment for services provided by an independently practicing physical therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. The statutory Medicare Part B outpatient therapy cap for physical therapy (PT) is $1,920.
PMIC	Medicaid plans must use utilization management guidelines established.

PRIMARY CARE ILLNESS/INJURY PHYSICIAN SERVICES	Medicaid plans must use utilization management guidelines established.
PROSTATE CANCER SCREEING	Medicaid plans must use utilization management guidelines established.
PROSTETICS	Medicaid plans must use utilization management guidelines established.
PULMONARY REHABILITATION	Medicaid plans must use utilization management guidelines established.
RADIATION THERAPY	Medicaid plans must use utilization management guidelines established.
SCREEING PAP TESTS	Medicaid plans must use utilization management guidelines established.
SCREENING MAMMOGRAPHY	Medicaid plans must use utilization management guidelines established.
SECOND SURGICAL OPTION	Medicaid plans must use utilization management guidelines established.
SKILLED NURSING SERVICES	Medicaid plans must use utilization management guidelines established.
SLEEP STUDIES	Medicaid plans must use utilization management guidelines established.
SPECIALTY PHYSICIAN SERVICES	Medicaid plans must use utilization management guidelines established.
SPEECH THERAPY	• Total Medicaid payment for services provided by an independently practicing speech therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). April 1, 2014, law was signed protecting access to Medicare act of 2014. The statutory Medicare Part B outpatient therapy cap for speech therapy (ST) is $1,920.
SUBSTANCE USE DISORDER INPATIENTTREATMENT	Medicaid plans shall use The ASAM Criteria as the utilization management guidelines for substance use disorder services.
SUBSTANCE USE DISORDER OUTPATIENT TREATMENT	Medicaid plans shall use The ASAM Criteria as the utilization management guidelines for substance use disorder services.
TMJ TREATMENT	Medicaid plans must use utilization management guidelines established.
TOBACCO CESSATION	Medicaid plans must use utilization management guidelines established.
TOBACCO CESSATION FOR PREGNANT WOMEN	Medicaid plans must use utilization management guidelines established.
TRANSPLANT - ORGAN AND TISSUE	Medicaid plans must use utilization management guidelines established.

URGENT CARE CENTERS/FACILITIES EMERGENCY CLINICS (NON-HOSPITAL BASED)	Medicaid plans must use utilization management guidelines established.
VISION CARE EXAMS	• Routine eye examinations are covered once in a 12-month period.
VISION FRAMES AND LENSES	• Frame services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1 through 3 years of age, one frame every 12 months for children 4-7 years of age and once every 24 months after 8 years of age. Safety frames are allowed for children through 7 years of age. • Single vision and multifocal lens services are limited up to 3 times for children up to 1 year of age, up to 4 times per year for children 1-3 years of age, once every 12 months for children 4-7 years of age, once every 24 months after 8 years of age. • Gas permeable contact lenses are limited as follow: up to 16 lenses for children up to 1 year of age, up to 8 lenses every 12 months for children 1-3 years of age, up to 6 lenses every 12 months for children 4-7 years of age, two lenses every 24 months for members 8 years of age and over. • Replacement of glasses that have been lost or damaged beyond repair are covered for adults age 21 and over is limited to once every 12 months. Replacement for lost or damaged glasses for children less than 21 years of age is not limited.
WALK-IN CENTER SERVICES	Medicaid plans must use utilization management guidelines established.
X-RAYS	Medicaid plans must use utilization management guidelines established.
**ALL OTHER SERVICES IN STATE PLAN OR APPLICABLE WAIVERS THAT ARE NOT LISTED ABOVE OR ARE ADDED IN THE FUTURE	Medicaid plans must use utilization management guidelines established.

TABLE 2: IOWA WELLNESS PLAN BENEFITS COVERAGE LIST

Service Category	Covered	Duration, Scope, exclusions, and Limitations	Excluded Coding
1. Ambulatory Services			
Primary Care Illness/injury Physician Services	✓		
Specialty Physician Visits	✓		
Home Health Services	✓	Not Covered: Private Duty Nursing/Personal Care	Not Covered: Procedure code S9122 or REV codes 570 or 571
Chiropractic Care therapeutic adjustive manipulative	✓		
Outpatient surgery	✓		
Second Surgical Opinion	✓		
Allergy Testing & Injections	✓		
Chemotherapy- Outpatient	✓		
IV Infusion Services	✓		
Radiation Therapy Outpatient	✓		
Dialysis	✓		
Anesthesia	✓		
Walk-in Centers	✓		

AIDS/HIV parity	✓		
Access to clinical trials	✓	Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	
Genetic Counseling	✓	Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of tx and not just informational.	
2. Emergency Services			
Emergency Room Services	✓		
Emergency Transportation-Ambulance and Air Ambulance	✓	Reviewed for medical necessity prior to payment.	
Urgent Care Centers/Facilities Emergency Clinics (non-hospital)	✓		
3. Hospitalization			
General Inpatient Hospital Care	✓		
Inpatient Physician Services	✓		
Inpatient Surgical Services	✓		
Non-Cosmetic Reconstructive Surgery	✓		
Transplant Organ and Tissue	✓	Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel. Not Covered- transport of living donor, services/supplies related to mechanical or non-human organs, transplant services and supplies not listed in this section including complications.	

Congenital Abnormalities Correction	✓		
Anesthesia	✓		
Hospice Care - Inpatient	✓		
Hospice Respite - Inpatient	✓	Limited to 15 days per lifetime for inpatient respite care. 15 days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than 5 days at a time.	Revenue code for Hospice Respite: 655
Chemotherapy - Inpatient	✓		
Radiation Therapy - Inpatient	✓		
Breast Reconstruction	✓		
4. Maternity & Newborn Care			
Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & Inpatient maternity - Nutritional	✓	Member is required to report pregnancy and eligibility for consideration of benefits under the Medicaid State Plan.	
Tobacco Cessation for Pregnant Women	✓		
Midwife Services	✓		
Newborn child coverage	✓		
5. Mental Health Behavioral Health Substance Use Disorder			
Mental Health/Behavioral Health Inpatient Treatment	✓	Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019

Mental Health/Behavioral Health Outpatient Treatment	✓	Those with disabling mental disorders will be considered medically exempt and enrolled in the Medicaid State Plan.	
Substance Use Disorder Inpatient Treatment	✓	Members with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid State Plan. Residential treatment is not covered.	Not covered: Code H0019
Substance Use Disorder Outpatient Treatment	✓	Members with disabling substance use disorder will be considered medically exempt and enrolled in the Medicaid State Plan.	
6. Prescription Drugs			
Prescription Drugs	✓		
7. Rehabilitative and Habilitative Services and Devices			
Physical Therapy, Occupational Therapy, Speech Therapy	✓	Each therapy is limited to 60 visits per year. Occupational only for upper extremities. Not covered- OT supplies, IP OT/PT in the absence of separate medical condition requiring hospitalization.	Each therapy is limited to 60 per year: Therapy services must be billed with the GP, GO, or GN modifier. Refer to Medicare's guidance on billing of therapy services.
Inhalation therapy	✓	Limit of 60 visits in a 12 month period.	N/A

Medical and Surgical supplies	✓	Non-covered- elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription	
Durable Medical Equipment	✓	Non-covered items include: elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available for purchase without a prescription.	
Orthotics	✓		
Prosthetics	✓		
Cardiac Rehabilitation	✓		
Pulmonary Rehabilitation	✓		
Skilled Nursing Services	✓	Covered in nursing facilities, skilled nursing facilities and hospital swing beds.	This service is limited to 120 days per year.
8. Laboratory Services			
Lab Tests	✓		
X-Rays	✓		
Imaging/Diagnostics **MRI CT PET**	✓		
Sleep Studies	✓	Treatment for snoring not covered. Claims must be for a diagnosis of sleep apnea.	Services 95800-95811 are covered but not with a diagnosis of 786.09.
Diagnostic Genetic Tests	✓	Requires prior authorization	
Pathology	✓		

9. Preventive Wellness Chronic Disease Management			
Preventive Care	✓	Limited to ACA required preventive services.	
Nutritional Counseling	✓	Max 40 units allowed for 12 month period	Not covered: 97802, 97803, G0270
Nutritional Counseling	✓	Max 20 units allowed for 12 month period	Not covered: 97804 & G0271
Counseling and Education Services	✓	Not covered: Bereavement, family, or marriage counseling. Education other than diabetes.	N/A
Family Planning	✓		
Vision Care Exams (Adult)	✓	Codes only allowed once per year: 92002, 92004, 92012, 92014. This does not limit the medical exams for members. Medical exams should be coded properly for accurate claim adjudication.	Not covered: V2020, V2025, V2100-V2115, V2118, V2121, V2199, V2200- V2221, V2299, V2300-V2315, V2318- V2321, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520-V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391, V2399, V2410, V2430, V2499, V2500-V2503, V2510-V2513, V2520- V2523, V2530-V2531, V2599, V2600, V2610, V2615, V2700-V2799, 76512, 92015, 92310, 92314, 92325, 92326, 92340, 92341, 92342, 92370, 92390, 92391
Immunizations	✓	Not covered- immunizations for travel	Not covered: 90476, 90477, 90581, 90585, 90586, 90665, 90690, 90691, 90692, 90693, 90717, 90725, 90727, 90735, 90738
Colorectal Cancer Screening	✓		

Screening Mammography	✓	One per year 77057, 77052, G0202	
Hearing Exam (Adult)	✓	Limit of one hearing exam per year. Codes only allowed once per year: 92551, 92552, 92553, 92555, 92556, 92557 92558, 92559, 92560, V5008	Not covered: V5010, V5014, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5120, V5130, V5140, V5150, V5160, V5170, V5180, V5190, V5200, V5210, V5220, V5230, V5240, V5264, V5266, V5267, V5298, V5299
Diabetes - med necessary equip & supplies Education	✓		
Screening Pap tests	✓		
Gynecological exam	✓	One per year	
Prostate cancer screening	✓	One per year for men age 50-64 years	
Foot Care	✓	Must be related to medical condition, routine services are not covered.	
Tobacco Cessation	✓	Immunizations and medical eval for nicotine dependence	
10. Pediatric Services including oral & vision			
EPSDT Ages 19 and 20	✓	Covered for ages 19-20	

Benefits Not Provided			
Acupuncture	**X**	Not covered	
Infertility Diagnosis and Treatment	**X**	Not covered- infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and tx, and tubal/vasectomy reversals, fertility drugs.	
Bariatric Surgery	**X**	Not covered.	Not covered: 00797, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774,43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2083 DRGs:619, 620, 621
Residential Services	**X**		
Non-emergency Transportation Services	**X**	Covered only for members determined Medically Exempt.	Covered only for members determined Medically Exempt.
Tobacco Cessation	**X**	Not covered	
TMJ	**X**	Not covered	Not covered for primary diagnosis of: 524.60, 524.61, 524.62, 524.63, 524.64, or 524.69
Breast Reduction	**X**		CPT codes 19318 or 19316, ICD proc codes: 85.31, 85.32, 85.6. Code 00402 not covered if billed with diagnosis 611.1.
Hearing Aid	**X**	Not covered	
Frames and lenses	**X**	Not covered	

TABLE 3: IDPH PARTICIPANTS COVERED BENEFITS

Outpatient Treatment
Intensive Outpatient
Partial Hospitalization (Day Treatment)
Clinically Managed Low Intensity Residential Treatment
Clinically Managed Medium Intensity Residential Treatment
Clinically Managed High Intensity Residential Treatment
Medically Monitored Intensive Inpatient Treatment
Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening, and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases
Evaluation, treatment planning and service coordination
All services appropriately provided as part of substance use disorder treatment. Such services would vary according to the level of service, and may include, but not necessarily be limited to, the following: • Lodging and dietary services; • Physician, physician assistant, psychologist, nurse, certified addictions counselor, social worker, and trained staff services; • Rehabilitation therapy and counseling; • Family counseling and intervention for the primary recipient of services, including co-dependent/collateral counseling with primary recipient of services; • Diagnostic X-ray, specific to substance use disorder treatment; • Diagnostic urine testing, specific to substance use disorder treatment; • Psychiatric, psychological and medical laboratory testing, specific to substance use disorder treatment; • Equipment and supplies; • Cost of prescription drugs
Substance use disorder counseling services when provided by approved opioid treatment programs that are licensed under Iowa Code Chapter 125 (The costs of Buprenorphine and Methadone dispensing will not be covered)

Substance use disorder treatment for IDPH Participants convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and IDPH Participants whose driving licenses or non-resident operating privileges are revoked under Chapter 321J, provided that such treatment service meets the criteria for service necessity and sliding fee scale
Court-ordered evaluation for substance use disorder

TABLE 4: *HAWK-I* Covered Benefits

Inpatient hospital services • Medical • Surgical • Intensive care unit • Mental health • Substance use disorder

Physician services • Surgical • Medical • Office visits • Newborn care • Well-baby • Well-child • Immunizations • Urgent care • Specialist care • Allergy testing and treatment • Mental health visits • Substance use disorder visits The Medicaid plan shall use the Recommended Childhood Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP), The American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), as the immunization schedule. The Medicaid plan shall incorporate the "Recommendations for Preventive Pediatric Health Care" by the AAP as the schedule for preventive care for children and adolescents. In lieu of the above, the Medicaid plan may use the most current version of the U.S. Preventive Task Force, “Guide to Clinical Preventive Services” as the immunization and preventive care schedule for children and adolescents.
Outpatient hospital services • Emergency room • Surgery • Lab • X-ray • Other services
Ambulance services
Physical therapy
Nursing care services (including skilled nursing facility services)
Speech therapy
Durable medical equipment
Home health care
Hospice services
Prescription drugs

Hearing services
Vision services (including corrective lenses)
Maternity and mental health services not inconsistent with 42 U.S.C.A § 1396u-2(b)(8)