



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IA - 22 - 0006

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations ABPI

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

Alternative Benefit Plan Population Name:

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).

Geographic Area

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

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

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.20140415

Transmittal Number: IA 22-0006
Supersedes: IA 20-0015

Approval Date: May 18, 2022
Effective Date: January 1, 2022



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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 (whether sent from 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.



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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



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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:

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.



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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.

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V.20130807



Alternative Benefit Plan

I. 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



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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



Alternative Benefit Plan

Benefit Provided: Anesthesia	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: 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.		
Benefit Provided: Urgent Care/Walkin Centers	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: 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.		
Benefit Provided: Access to Clinical Trials	Source: Base Benchmark State Employees	Remove
Authorization: None	Provider Qualifications: Medicaid State Plan	
Amount Limit: None	Duration Limit: None	
Scope Limit: None		



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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).

Benefit Provided:

Hospice Care - Outpatient

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:

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.

Benefit Provided:

Inhalation Therapy

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

60 visits per benefit year.

Scope Limit:

None



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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 facility is in or out of network.

Add



Alternative Benefit Plan

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

Hospitals and Facilities

Benefit Provided:

Non-cosmetic Reconstructive Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Cosmetic services, supplies 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

Benefit Provided:

Transplant Organ and Tissue

Source:

Base Benchmark State Employees

Remove

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

Benefit Provided:

Congenital abnormalities correction

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

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:

inpatient 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.



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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

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.

Benefit Provided:

Substance Abuse Outpatient Treatment

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:

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



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



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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



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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



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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).

Benefit Provided:	Source:	Remove
Hearing Exam - Adult	Base Benchmark State Employees	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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		

Benefit Provided:	Source:	Remove
Diabetes-med necessary equip & supplies	Base Benchmark State Employees	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	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.		

Benefit Provided:	Source:	Remove
Prostate cancer screening	Base Benchmark State Employees	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	one exam per year	



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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



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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



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14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Dental Coverage

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 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.

Transmittal Number: IA 22-0006

Supersedes: IA 20-0015

Approval Date: May 18, 2022

Effective Date: January 1, 2022



Alternative Benefit Plan

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



Alternative Benefit Plan

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

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V.20160722



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).

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V.20130807



Alternative Benefit Plan

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:

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:

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



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

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

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