is no longer collected and the co-payment is no longer deducted from claims reimbursement to providers.

It is expected that the MCOs will intervene to educate enrollees about the appropriate use of ER services prior to any family utilizing the ER inappropriately in as many instances indicated in the chart.

No. of children in family	Annual Income at 302% FPL	5% Premium Maximum		5% minus premium maximum	No. of Annual Inappropriate ER Visits
1	$35,545	$1,777.25	$240	$1,537.25	($1537.25/$25) 62
2	$48,109	$2,405.45	$480	$1925.45	($1925.45/$25) 77
3	$60,672	$3,033.60	$480	$2,553.60	($2553.60/$25) 102
4	$73,235	$3,661.75	$480	$3,181.75	($3181.75/$25) 127
5	$85.798	$4289.90	$480	$3809.90	($3809.90/$25) 152
6	$ 98,361	$4918.05	$480	$4438.05	($4438.05/$25) 178
7	$110,925	$5,546.25	$480	$5066.25	($5066.25/$25) 203
8	$123,488	$6,174.40	$480	$5,694.40	($ 5694.40/$25) 228

No cost-sharing is assessed for eligible Native American / Alaskan Native children regardless of family income for both the hawk-i program and the dental only program.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The brochure that contains the hawk-i application states that there is no cost sharing for American Indian/Alaskan Native children. At the time the applicant is approved for the hawk-i program, an approval notice is sent indicating there is no cost sharing. These provisions are also found in the Iowa Administrative Code at 441- 86.8(1). Applications to the hawk-i program ask for the race of the children applying. When race is indicated as Native American or Alaska Native, no cost sharing is assessed to American Indian or Alaska Native children, regardless of income.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Premiums are due by the 5th day (or the next business day, if the 5th falls on a holiday or weekend) of the month prior to the coverage month. If the premium has not been received by the 5th or the next business day, if the 5th falls on a holiday or weekend, a reminder notice is sent. All notices of adverse action contain appeal rights language on the reverse side. The following example illustrates the actions associated with the premium for the coverage month of November.

Date	Action	Length of Time

September 5th	Invoice for November is sent	
October 5th	November premium is due and invoice for December is sent.	30 days from when the original invoice is sent.

Initial Application: When an approval decision has been made on an initial application, the first premium due is for the third month of the twelve-month enrollment period. Example: A child is approved on October 15th with an effective date of November 1st. The first premium is due on December 5th for the month of January.

Renewal Application: When an approval decision has been made on a renewal application, the first premium due is the first month of the new twelve-month enrollment period.
Example: The initial enrollment period ends November 30th. The renewal application is received in September and approved in September for a new enrollment period. The first premium due is October 5th for November (the first month of the enrollment period).

If a family reports a decrease in income and a premium is no longer required, premiums will no longer be charged beginning with the month following the month of the report of the change.

At State discretion, the premium lock-out policy may be temporarily suspended and coverage available regardless of whether the family has paid their outstanding premium for existing beneficiaries who reside and/or work in a disaster area for a specified period of time during a national emergency declared by both the President and the Secretary of the Department of Health and Human Services, a State-declared emergency, or any situation in which an emergency continues in Iowa beyond such time as a national emergency ends. Additionally, at the State's discretion, the lock-out policy may continue to be waived for a specified time period after the duration of an emergency.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to

payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
The state will no longer disenroll members due non-payment of premium.

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
The state will no longer disenroll members due non-payment of premium.

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration