IOWA | Health and Human Services

Number: 501-MH
Title: MH Service Note Review
Effective Date: 10/01/2022
Date of Last Review: 10/27/2025
Authority: IDPH/DHS Omnibus Agreement, 441 IAC 79.3

Overview

Service Note Review (SNR) applies to Presumptive Eligibility (PE) and Care Coordination (CC) services provided as part the Contractor's MH program regardless of payer source. The SNR is conducted per the contract. Reviewers must have knowledge of the program requirements, services, and have access to the MCAH Data System. MH Directors serve as the primary contact for the review.

Policy

Contractors will conduct SNR as specified in the contract to review documentation of Presumptive Eligibility and Care Coordination to ensure compliance with department requirements for documentation.

Required Resources for Implementation

The Department provides a list of Contact IDs and forms to complete the SNR.

Documentation: The following documentation is required for each service:

1. **Presumptive Eligibility:**
   a. Demographics including race, ethnicity, primary language, and interpreter needed
   b. Coverage Explained
   c. Result of Notice of Award (NOA)
   d. NOA number
   e. County of residence
   f. Contacted person
   g. Client/family feedback
   h. Documents kept on file and documents given to family
   i. First and last name of the service provider and their credentials.

2. **Care Coordination**
   a. Demographics including race, ethnicity, primary language, and interpreter needed
   b. County of residence
   c. First and last name of the service provider and their credentials
   d. Concerns and issues

e. Contacted person
f. Staff response
g. If coordinating medical/dental care:
    i. Medical appointment summary (name of provider; past or upcoming appointments)
    ii. Dental appointment summary (name of provider; past or upcoming appointments)
    iii. Referrals, outcomes, & plan for follow-up
    iv. Client/family feedback
    v. First and last name of service provider and their credentials.

For targeted follow-up care coordination notes that do not involve coordinating medical/dental care, the date of the last wellness exam and name of provider. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.

Procedure

1. SNR 1 will occur in the fall/winter of each FFY. SNR 2 will occur in the spring/summer of each FFY. The month selected by the Department for the data pull will be random.
2. For SNR 1, the Department will provide the Agency with a list of Contact IDs and blank Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
    a. The Contractor will review the Contractor documentation using the provided forms as a checklist for included elements. Complete the forms (including contact ID & service date) and by checking the “yes” or “no” boxes to indicate if the required elements of documentation are in the record. If there is more than one box marked “no” the record does not “pass.” An agency review comment field is available for your use for any additional comments (optional).
    b. If the Contractor did not provide a specific type of service to be reviewed, check the ‘No Services This Period’ box on the Service Note Review Summation that verifies this (e.g., if no presumptive eligibility services were provided during the month reviewed).
    c. Completed review tools are to be sent via confidential email, within 30 days from the start of the review process. Do not upload completed summation forms into IowaGrants.gov.
3. For SNR 2, the Department will provide the Agency with completed Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
    a. The Agency will use the completed forms and feedback provided by the Department to complete their own quality assurance activity.
4. SNR Quality Improvement Plans are required for Contractors that do not achieve 90% documentation compliance for their review, which will be calculated by summing the total service records submitted for review as the denominator, with the number in compliance (marked as pass) as the numerator.
    a. Contractors with continued non-compliance will be required to complete more frequent reviews and may be placed on a Corrective Action Plan, which may result in the reduction or elimination of funding or the enforcement of other remedies authorized by the contract.
    b. Required elements of the Quality Improvement Plan are the actions that will be taken to assure documentation is in compliance with this policy, the person completing this step and responsible for assuring documentation comes into compliance, and the timeline for when the steps will be taken.

2. Quality Improvement Plans should be submitted for approval and then uploaded into IowaGrants.gov to the Service Note Review - Quality Improvement Plan component of IowaGrants.gov. The plan must be uploaded to IowaGrants.gov within 30 days from the receipt of the SNR results from Iowa HHS IDPH.

Resources

Iowa Administrative Code [441] Chapter 79.3 4-6-2011.Rule.441.79.3.pdf (iowa.gov) IAC 79.3

Number: 501-CAH
Title: Service Note Review
Effective Date: 10/01/2022
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Date of Last Review: 08/27/2025
Authority: Iowa HHS Omnibus Agreement, Iowa Administrative Code [441] Chapter 79.3

Overview

Service Note Review (SNR) applies to Presumptive Eligibility (PE), Informing (INF), and Medical/Dental Care Coordination (CC) services provided as part of the Contractor's CAH program regardless of the payer source. The SNR is conducted per the contract. Reviewers must have knowledge of the program requirements and services and have access to the Maternal Health (MH) and Child & Adolescent Health (CAH) Data System. Project Directors serve as the primary contact for the review.

Policy

Contractors will conduct SNR as specified in the contract to review documentation of Presumptive Eligibility, Informing, Care Coordination, and home visits for Care Coordination to ensure Department compliance.

Required Resources for Implementation

The Department provides a list of Contact IDs and forms to complete the SNR.

Documentation: The following documentation is required for each service:

1. **Presumptive Eligibility:**
    a. Demographics including race, ethnicity, primary language, and interpreter needed
    b. Coverage Explained
    c. Result of Notice of Action (NOA)
    d. NOA number
    e. County of residence
    f. Contacted person
    g. Client/family feedback
    h. Documents kept on file and documents given to family
    i. First and last name of the service provider and their credentials.
    j. Intake assessment addressed with IRIS/IRIS component of the MCAH data system used to assess immunization status

2. **Informing:**
    a. Initial Inform:
        i. First and last name of the service provider and their credentials
        ii. Statement that an informing letter or packet was sent

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iii. County of residence

b. Inform Follow-up
   i. First and last name of the service provider and their credentials
   ii. County of residence
   iii. Description of the attempt to reach the family and the result of the attempt (no answer, phone disconnected, etc.), including any voicemail message left or text message sent and the content of the message
   iv. A follow-up letter is sent (after at least two failed attempts on two different dates)
   v. Follow-ups are required within 30 days of the initial inform
c. Inform Completion
   i. Demographics, including race, ethnicity, interpreter needed, and primary language
   ii. First and last name of the service provider and their credentials
   iii. County of residence
   iv. Contacted person
   v. Explanation of full benefits and services available under the EPSDT Program
   vi. Medical well-visit appointment summary (name of provider; past or upcoming appointments)
   vii. Dental appointment summary (name of provider; past or upcoming appointments)
   viii. IRIS/IRIS component of the MCAH Data System used to assess immunizations
   ix. Client/family feedback provided
   x. Referrals, outcomes, and plan for follow-up
   xi. Intake assessment addressed

3. **Care Coordination**
   a. Demographics including race, ethnicity, primary language, and interpreter needed
   b. County of residence
   c. First and last name of the service provider and their credentials
   d. Concerns and issues
   e. Contacted person
   f. Staff response

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g. If coordinating medical/dental care:
    i. Dental appointment summary (name of provider; past or upcoming appointments)
    ii. Medical appointment summary (name of provider; past or upcoming appointments)
    iii. IRIS/IRIS component of the MCAH Data System used to assess immunizations or caretaker reports if completed by OH staff
    iv. Referrals, outcomes, & plan for follow-up
    v. Client/family feedback provided
    vi. Intake assessment addressed

For **targeted follow-up care coordination** notes that do not involve coordinating medical/dental care, the date of the last wellness exam, name of provider, and assessment of immunization status are not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.

Procedure

1. SNR 1 will occur in the fall/winter of each FFY. SNR 2 will occur in the spring/summer of each FFY. The month selected by the Department for the data pull will be random.
2. For SNR 1, the Department will provide the Agency with a list of Contact IDs and blank Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
    a. The Contractor will review the Contractor documentation using the provided forms as a checklist for included elements. Complete the forms (including contact ID & service date) and by checking the “yes” or “no” boxes to indicate if the required elements of documentation are in the record. If there is more than one box marked “no” the record does not “pass.” An agency review comment field is available for your use for any additional comments (optional).
    b. If the Contractor did not provide a specific type of service to be reviewed, check the ‘No Services This Period’ box on the Service Note Review Summation that verifies this (e.g., if no presumptive eligibility services were provided during the month reviewed).

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   c. Completed review tools are to be sent via confidential email within 30 days from the start of the review process. Do not upload completed summation forms to IowaGrants.gov.
3. For SNR 2, the Department will provide the Contractor with completed Service Note Summations (Child Health: PE, INF, CC. Maternal Health: PE, CC).
   a. The Contractor will use the completed forms and feedback provided by the Department to complete their own quality assurance activity.
4. SNR Quality Improvement Plans are required for Contractors that do not achieve 90% documentation compliance for their review. The compliance rate will be calculated by summing the total service records submitted for review as the denominator, with the number in compliance (marked as pass) as the numerator.
   a. Contractors with continued non-compliance will be required to complete more frequent reviews and may be placed on a Corrective Action Plan, which may result in the reduction or elimination of funding or the enforcement of other remedies authorized by the contract.
   b. Required elements of the Quality Improvement Plan are the actions that will be taken to ensure documentation is in compliance with this policy, the person completing this step and responsible for assuring documentation comes into compliance, and the timeline for when the steps will be taken.
   c. Quality Improvement Plans should be submitted for approval and then uploaded into the Correspondence section of Iowa Grants. The plan must be uploaded to IowaGrants.gov within 30 days of the receipt of the SNR results from the Department.

Resources
Iowa Administrative Code [441] Chapter 79.3

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Number: 502-MH
Title: MH Medical Record Audit
Effective Date: 10/01/2022
Revision Date: 10/27/2025
Date of Last Review: 10/27/2025
Authority: Iowa HHS General Conditions for Service Contracts, IDPH/DHS Omnibus Agreement, 441 IAC 79.3

Overview

The Department MH medical record audit is part of the quality assurance program and the intent is to evaluate Contractor's current practices and identify areas to improve quality of service delivery and documentation. Presumptive Eligibility and care coordination are not included in these medical record audit guidelines as they are reviewed during the service note review process (see Policy 501-MH, MH Service Note Review).

Policy

1. Medical record audits are required of all Contractors.
2. Virtual or in-person medical record audits may occur at the discretion of the state Title V program.
3. Contractors must enter all direct health care services provided for clients under the MH program into the MCAH data system. Documentation of the clinical detail for direct health care services must also be maintained in a client's medical record (paper or electronic). Both of these forms of documentation will be reviewed during the audit.
4. Documentation of services must comply with generally accepted principles for maintaining health care records and with Medicaid requirements established by the Iowa DHS in IAC 441 - 79.3.

Procedure

Internal Medical Record Audit: At least one Contractor-conducted (internal) medical record audit must be completed in any contract period where a joint audit is not completed. Following the internal medical record audit, the Contractor is required to submit completed review tools and a MCAH Medical Record Audit Summary form, complete with plans for quality improvement based upon the audit findings. The Contractor's internal medical record audit team will be a multidisciplinary team representative of the disciplines providing MH services (e.g., nurse, social worker, dental hygienist). Contractors shall include subcontractors in the audit process.

Joint medical record Audit: Opposite years from the internal medical record audit or as determined by the Department, the Contractor is required to have an audit conducted by a joint review team composed of Contractor and subcontractor staff and staff from the relevant Department programs. The audit team, including Department staff, must be large enough so that each team member reviews at least one and no more than three medical records.

Medical Record Audit Process:

1. The Contractor shall randomly select charts for review using the **Medical Record Selection Requirements** listed below.

2. **Internal Medical Record Audit Process:**

a. The contractor's multi-disciplinary team shall review all selected charts using the most updated medical record audit tools

b. The review team shall convene to discuss their review findings

c. The contractor shall complete a single Medical Record Audit Summary and submit to the Department a minimum of one week prior to the scheduled site visit.

3. **Joint Medical Record Audit Process:**

a. Department and contractor staff shall review the medical records using the most updated medical record audit tools prior to the scheduled virtual audit meeting. Each year's medical records audit tools can be found on the Maternal and Child Health Portal.

b. Medical records shall be sent to the Department at least 5 business days in advance of the scheduled audit via fax, secure email, or via google folder. Ensure the medical records include the MCAH data system ID, any paper documentation, and all electronic medical records related to the entire pregnancy (even if some services took place outside the specified timeframe).

c. If mailing medical records, you must send at least two weeks prior to the audit, to the Lucas Building. Follow your agency's protocol for mailing documents with protected health information.

4. Contractors will ensure that their staff auditing medical records have access to the MCAH data system. If staff do not have access, time should be scheduled for reviewers to work with staff who do have access.

5. The MH Director should set aside time with their staff ahead of time to review the required tools and expectations of medical record audits. MH Directors will assign medical records to reviewers.

6. Contractors and Department staff should review assigned medical records independently prior to the scheduled site visit. Contractors may choose to meet prior to the debriefing session to discuss any questions or jointly review medical records.

7. A designated time for the debriefing must be set during the Maternal Health Site Visit so that Department Oral Health staff and contractor staff not participating in the full site visit can attend the Medical Record Audit Debrief.

8. Debriefing session will consist of a round-table style share of medical record audit findings for strengths and areas for improvement and completion of the Medical Record Audit Summary. The Department consultant will complete the Medical Record Audit Summary and send to the contractor to complete a Quality Improvement Plan, if required.

Medical Record Audit Summary: Contractors shall complete one MH Medical Record Audit Summary for the entire medical record audit process. Areas to be addressed include:

1. **Strengths**: Summarize strengths identified through the medical record audit process. These may pertain to program implementation and/or documentation.

2. **Telehealth Technology:** In review of the documentation is the technology used for telehealth HIPAA compliant? (If more than one platform is in use are they all HIPAA compliant?)

3. **Recommendations for Improvement:** Identify recommendations for improving program implementation and/or documentation.

4. **Plans for Quality Improvement:** Identify actions to be initiated in response to findings of this review. Include how results will be shared with staff to improve practice and enhance program development. Specify the person responsible, the projected date of completion for each activity, and how quality improvement will be measured. Provide adequate narrative to fully describe the assessment and plan for quality improvement.

Audit Due Date and Submission: Internal and joint medical record audit results are due to the Department on the date listed in the contract. A copy of the completed MH medical record audit tools (including quality improvement plans based upon audit findings) and the Medical Record Audit Summary are to be sent via secure mail, fax, or regular mail to the consultant. When sending records for Department review as part of the joint audit or with findings in the internal audit, secure methods (encrypted email, etc.) must be used to protect patient confidentiality.

Documentation at Iowa HHS: Once the review tools and summary tool is complete for the contractor, the consultant will upload the summary tool to IowaGrants.gov.

Medical Record Selection Requirements: The following is the required record selection criteria:

1. A minimum of ten MH medical records for clients who have been discharged and had at least one service in the previous 12 months.
2. The following must be included in at least one chart if services were provided:

a. Oral health services

b. Oral Health Only clients

c. Lactation Classes

d. Listening Visits

e. Postpartum Only

f. Clinic visit

g. Home visit

h. Depression Screen

i. SBIRT

3. At least one record from each subcontractor must be reviewed.
4. At least one record from each service site type must be reviewed (e.g., home visits, WIC, school, OB clinic, agency clinic, etc.).
5. If the Contractor has 10 or less service providers (in the service area, including subcontractors and other agreements), at least one record from each service provider must be reviewed.
6. If the Contractor has more than 10 service providers (in the service area, including subcontractors and other agreements) a minimum of 10 different service providers must be reviewed.

Contractors that subcontract or have another form of agreement with another Title V Contractor to provide services in their service area shall work with the subcontract Title V Contractor and Department consultant in advance of the medical record audit to decide if the records will be reviewed as part of the Contractor's medical record audit or part of the subcontractor's medical record audit.

Resources

Maternal Health Center Provider Manual

Iowa HHS General Conditions for Service Contracts

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Number: 502-CAH
Title: Medical Record Audit
Effective Date: 10/01/2016
Revision Date: 08/27/2025
Date of Last Review: 08/27/2025
Authority: HHS General Conditions for Service Contracts, HHS Omnibus Agreement

Overview

The Iowa Department of Health and Human Services Child and Adolescent Health (CAH) medical record audit is part of the quality improvement program, and the intent is to evaluate the contractor's current practices and identify areas to improve the quality-of-service delivery and documentation. Presumptive Eligibility, Informing, and Care Coordination are not included in these medical record audit guidelines as they are reviewed during the service note review process (see Policy 501 Service Note Review).

Policy

1. Medical record audits are required of all contractors providing gap-filling direct health care and oral health services. Medical record audits apply to all gap-filling direct care services provided through the CAH program regardless of payer source. CAH gap-filling direct care services include the following services as defined in the Screening Center Provider Manual.
2. Virtual or in-person medical record audits may occur at the discretion of the state Title V program.
3. All gap-filling direct health care services provided for clients under the CAH program must be entered into the Maternal Child and Adolescent Health (MCAH) data system. Documentation of the clinical detail for gap-filling direct health care services must also be maintained in a client's medical record (paper or electronic). Both of these forms of documentation will be reviewed during the audit.
4. Documentation of services must comply with generally accepted principles for maintaining health care records and with Medicaid requirements established by the Iowa Department of Health and Human Services (Iowa HHS) in IAC 441 Chapter 79.3.

Procedure

Internal Medical Record Audit: At least one contractor-conducted (internal) medical record audit must be completed every other year. Following the internal medical record audit, the Contractor is required to submit a MCAH Medical Record Audit Summary form, complete with plans for quality improvement based on the audit findings.
The contractor's internal medical record audit team will be a multidisciplinary team representative of the disciplines providing CAH services (e.g., nurse, social worker, dental hygienist). Contractors shall include subcontractors in the audit process.

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Joint Medical Record Audit: Opposite years from the internal medical record audit, the contractor is required to have an audit conducted by a joint review team composed of contractor and subcontractor staff and staff from the Iowa HHS CAH Program. The audit team, including CAH staff, must be large enough so that each team member reviews one to five medical records.

Medical Record Audit Process:

1. A minimum of one week prior to the audit (internal or joint), the Department will provide the contractor with a list of ID numbers randomly selected from the MCAH data system using the selection criteria found in the *Medical Record Selection Requirements* section found below.
2. The contractor shall carefully review the list of ID numbers provided by the MCAH data system to ensure that the selected medical records meet the required selection criteria. Due to the complex nature of selecting IDs that meet all criteria, contractors may not need to review all the medical records included in the list of selected medical records **IF** they have otherwise met the selection criteria outlined below. Some IDs may need to be swapped out for a different ID due to a nuance or error. Contractors wanting to alter the list, review fewer records, or review alternate records shall notify the consultant and get approval.
3. Department and contractor staff shall review the medical records using the most updated medical record audit tools prior to the scheduled audit meeting.
4. For joint audits, the Department will select the ID numbers of the records for CAH staff to review. Most contractors utilize some form of medical record outside of the MCAH data system, whether electronic or paper. In order for the Department staff to properly audit the selected medical records, the contractor shall send the medical records to the Department for each team member to review. The contractor only needs to send non-MCAH data system records to complete the audit for each medical record, as the consultants will have access directly to the MCAH data system for review.
    a. Medical records must be sent to the Department at least five business days in advance of the scheduled audit via secure email. Ensure the medical records include the MCAH data system ID, any paper documentation, and all electronic medical records related to CAH services provided within the past 12 months.

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5. Contractors will ensure that their staff auditing medical records have access to the MCAH data system. If staff do not have access, time should be scheduled for reviewers to work with staff who do have access.
6. The CAH Project Director should set aside time with their staff ahead of time to review the required tools and expectations of medical record audits. CAH Project Directors will assign medical records to reviewers.
7. Contractors and Department staff review assigned medical records independently prior to the scheduled debrief. Contractors may choose to meet prior to the debriefing session to discuss any questions or jointly review medical records.
8. The debriefing session will consist of a round-table style share of medical record audit findings for strengths and areas for improvement and completion of the Medical Record Audit Summary.

Medical Record Audit Summary: One CAH Medical Record Audit Summary will be completed for the entire medical record audit process. Areas to be addressed include:

1. **Strengths**: Summarize strengths identified through the medical record audit process. These may pertain to program implementation and/or documentation.
2. **Telehealth Technology:** In a review of the documentation, is the technology used for telehealth HIPAA compliant? (If more than one platform is in use, are they all HIPAA compliant?)
3. **Recommendations for Improvement:** Identify recommendations for improving program implementation and/or documentation.
4. **Plans for Quality Improvement:** Identify actions to be initiated in response to the findings of this review. Include how results will be shared with staff to improve practice and enhance program development. Specify the person responsible, the projected date of completion for each activity, and how quality improvement will be measured. Provide adequate narrative to fully describe the assessment and plan for quality improvement.

Audit Due Date and Submission: Internal and joint medical record audit results are due to the Department by the date listed in the contract. A copy of the completed Medical Record Audit Summary will be sent via secure mail to the consultant and/or CAH staff completing the audit. When sending records for Department review as part of

the joint audit or with findings in the internal audit, secure methods (encrypted email, etc.) must be used to protect patient confidentiality.

Documentation at Iowa HHS: Once the summary tool is complete for the contractor, CAH staff will upload the summary tool to IowaGrants.gov.

Medical Record Selection Requirements: The following is the required record selection criteria:

1. A minimum of ten CAH medical records for gap-filling direct care services delivered in the 12 months prior to the audit. CAH records may be open or closed at the time of the audit, but the services being reviewed should be complete (e.g., lead tests should have results back and follow-up with the family and primary care provider documented.).
2. Oral health services must be included in the medical record audit.
3. At least one record of each type of gap-filling direct care service provided in the previous 12 months must be reviewed.
4. At least one record from each subcontractor must be reviewed.
5. At least one record from each service site type must be reviewed (e.g., home visits, WIC, school, agency clinic, etc.).
6. If the contractor has 20 or less service providers (in the service area, including subcontractors and other agreements), at least one record from each service provider must be reviewed.
7. If the contractor has more than 20 service providers (in the service area, including subcontractors and other agreements), a minimum of 20 different service providers must be reviewed.

Contractors that subcontract or have another form of agreement with another Title V contractor to provide services in their service area shall work with the subcontract Title V contractor and CAH consultant in advance of the medical record audit to decide if the records will be reviewed as part of the contractor's medical record audit or part of the subcontractor's medical record audit.

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Resources

Screening Center Provider Manual
HHS General Conditions for Service Contracts

Sources

HHS Omnibus Agreement

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Number: 503
Title: Cost Analysis
Effective Date: 10/01/2016
Revision Date: 08/28/2025
Date of Last Review: 08/28/2025
Authority: Office of Management and Budget Circular 2 CFR Part 200; 2 CFR Part 225; 2 CFR Part 230; 2 CFR 215

Overview
The cost analysis establishes the amounts to be billed for each Maternal Health (MH), Child & Adolescent Health (CAH) and/or Oral Health (OH) service provided. Time studies to justify salaries are required by the Office of the Inspector General and the federal Office of Management and Budget (OMB). The Iowa HHS Title V MCAH program establishes approximate costs for all direct services across the state using a Customized Fee Analyzer specific for the state of Iowa.

Policy
All Contractors must adhere to the most recently approved Iowa HHS Costs for Title V MCAH Direct Services.

Procedure
1. Obtain the most recent approved Iowa HHS Costs for Title V MCAH Direct Services at the start of each project period. Contractors shall use the 50th percentile column of the fee as their cost.
2. Ensure the most recent costs are utilized when billing Medicaid MCOs for all MCAH services.
    a. Iowa HHS encourages contractors to determine their individual agency's costs for providing direct services to identify opportunities for improvement in clinic efficiencies and service provision.
3. Maintaining time studies are required for all staff working in the MCAH program. The MCAH Time Study form and instructions have been developed and shall be used for the continuous, daily time studies that must be completed and maintained on file. Contractors may submit an alternate time study form for review for approval and use.

Resources
Office of Management and Budget Circular 2 CFR Part 200; Subpart D - Post Federal Award; Subpart E-Cost Principles; and Subpart F-Audit Requirements
CFR Part 225, Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87);
2 CFR Part 230, Cost Principles for Non-Profit Organizations (OMB Circular A-122) or
2 CFR 215 Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations (OMB Circular A-110)

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Number: 506
Title: Time Study
Effective Date: 08/28/2025
Revision Date: 08/28/2025
Date of Last Review: 08/28/2025

Overview

Time studies account for the total amount of personnel time that is spent in each of the Child & Adolescent Health (CAH) components. This information is used to track personnel time invested in the CAH program and is a large portion of the cost of CAH activities and services. Time studies are completed every working day by each person working in the CAH program including Hawki Outreach, Early ACCESS, Healthy Child Care Iowa and Oral Health. Contractors shall require subcontractors to conduct time studies on all individuals working in the CAH program to track costs associated with the subcontract. The subcontract time study should be separate from the contractor's time study. *Time spent in programs outside of the Title V CAH contract, such as 1st Five, WIC, Maternal Health, the lead grant, family planning, or the immunization grant are not included in this time study.*

Policy

All Contractors must adhere to this policy and complete daily continuous time studies.

Procedure

1. When services are paid by multiple providers (public and private) on a fee-for-service basis, include the time for all clients served regardless of payment source. Activities include those necessary to provide services specified in the CAH application and include services to all children, adolescents and their families served under the CAH program, regardless of payment source (e.g. both Medicaid and non-Medicaid clients).
2. **Date**: Enter the range of dates covered in the time study - start day and ending day.
3. **Name & Credentials**: Name and credentials of staff completing the form (e.g. Nancy Barnes, RN).
4. **Job Title**: Job title or titles related to CAH contracted services
5. Time studies are completed after the fact and represent actual time spent on an activity, not the time scheduled to be worked. If there are changes in the schedule or if a client does not keep an appointment, enter the time in the component that most accurately reflects the activity actually completed during that time period.
6. Enter the total number of minutes worked for each area in the corresponding time slot. Refer to the information below for an explanation of areas.

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7. Round time to the nearest 10-minute interval. Be as accurate as possible.
8. Time is automatically converted to hours (or fractions of hours) for percent calculations.
9. Do not include personal time such as lunch or unpaid leave.
10. Vacation, sick, and other paid leave are allocated based on average monthly percentage.
    a. For example, a staff person normally works 20 hours per week (75% in the MAF component and 25% in the Hawki & PE). If this person takes a week of paid vacation time, then the vacation time should be spread proportionately across the cost centers for that week. In this example, 15 hours (75%) of the vacation time would be allocated to MAF and 5 (25%) hours would be allocated to Hawki & PE.

Health Equity and Family Engagement
Activities
● Health Equity Training ● Creating/Providing culturally and linguistically appropriate materials and services ● Hiring, arranging interpreters and translations ● Assessing readability and accessibility of materials, websites, forms, etc. ● Incorporating people with lived experience in the development, review and distribution of materials ● Gathering input from priority populations ● Reviewing data for health equity ● Collaborating with organizations, programs or groups led by and/or specifically designed to serve priority populations ● Recruitment and retention of priority population staff ● Designing programs, services and activities to improve health outcomes for priority populations ● Gathering input from clients and family members ● Recruitment, orientation, logistics and meeting of family engagement group

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● Engaging in partnerships for the family engagement group
Funding sources for Health Equity and Family Engagement include Title V grant funds, MAF and program income.

Informing, Medical and Dental Care Coordination and Medical Home			
Services	**Service Activities**	**Support Activities**	**Considerations**
● Informing (initial Inform, Inform follow-ups, & Inform completion) ● Medical Care Coordination for Non-MCO and Title V clients ● Dental Care Coordination for all clients	● Sending the initial Inform letter ● Attempts to make personal contact with the individual or family ● Attempts to identify other options for contacting the family such as researching other internal agency records (e.g. WIC and Immunization	● Accessing and using needed reports ● Mailing an initial Inform letter/packet ● Mailing a follow-up letter following a minimum of two failed phone attempts to reach the family ● Maintaining tracking logs	● Any time for care coordination of a baby provided at a maternal health postpartum home visit is allocated to the Maternal Health Program unless the mother is not enrolled in the MH program. ● Medical care coordination should not be provided to those that are enrolled with a MCO unless the client calls the agency and requests assistance; in that case this time can be billed to CAH MAF. ● Any time related to care coordination that occurs on the same day as a direct care service is allocated to the corresponding direct care service. Exceptions are the following: ● Care coordination to arrange transportation.

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	clinic schedules) ● Checking with other resources for updated phone or address ● Phone calls/texts - sending/leaving messages. Time for documenting the inform attempt and outcome information (new phone number, phone disconnected, message left on machine or with specific individual)	of service activities ● Sign language or oral interpretation services provided for clients ● Quality assurance activities ● Attending staff development or meetings specifically related to specific services ● Translating documents & educational materials	● Medical care coordination provided with a dental direct service provided by other staff (RDH) on the same day (if no medical direct care was provided). ● Dental care coordination by RDH provided if a medical direct service is provided by other staff on the same day (if no dental direct care was provided). ● Dental care coordination provided on the same day as a direct service is paid for by the direct service but should be entered into the MCAH data system as dental care coordination with the payment source of “other”

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	● Explaining the services available under Medicaid's EPSDT program to families of newly eligible children ● Dialogue with individuals and families about the services available under EPSDT and the importance of preventive care ● Assessment of current health care needs ● Referrals to providers based on	related to services. ● Writing, updating and reviewing Informing and care coordination materials. ● Staff training related to Informing and care coordination ● Involving clients, families and priority populations in development of policy and procedures, review of materials and Informing and	

	assessment of needs ● Sending additional information to the family ● All dental care coordination ● Documentation in the MCAH data system ● Sending well child exam reminders	care coordination processes ● Building a referral network of providers to serve as medical and dental homes ● Promotion of health literacy ● Partnership building related to health literacy, care coordination and Informing	
Funding source for Informing is MAF. Funding sources for Medical Care Coordination include MAF, Title V grant funds for Title V only clients and program income. Funding for Medical Home activities include MAF, Title V and program income. Funding sources for Dental Care Coordination include MAF for all Medicaid-enrolled clients, CH Dental or I-Smile™ for all clients not enrolled in Medicaid.			

Immunization

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Enabling Services	● Enrolling in IRIS ● Assuring access to immunization services through care coordination, education and referrals
Public Health Services & Systems	● Providing immunization information and promotion to clients, families, stakeholders, and the public ● Promotion of initiation and completion of HPV vaccination
Funding for enabling and public health services and systems is Title V or program income.	

Lead	
Enabling	● Educate families on the importance of blood lead testing at recommended age intervals (e.g., informing scripts, initial inform mailing, social media platforms). Basic outreach is allowed.
Public Health Services & Systems	● Community partnership activities ● Priority population partnership activities ● CLPPP partnership activities ● Testing promotion
Funding for enabling and public health services and systems is Title V or program income.	

Early ACCESS	
Enabling	● Receive referrals from AEA to provide developmental screening follow-up for children, 0 to age 3, who did not qualify for Early ACCESS

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Public Health Services & Systems	● Develop a written referral process for the Area Education Agency (AEA) to refer infants and toddlers, ages 0 to 3 years, found not eligible for Early ACCESS to the CAH program for ongoing developmental monitoring ● Promote Early ACCESS to families and others that work with young children in applicant's service area. ● Document Early ACCESS promotional activities in Community Events in MCAH data system
Funding for enabling and public health services and systems is Title V or program income.	

Healthy Child Care Iowa
All activities included in and related to the Iowa CCNC Role Guidance
Funding for enabling and public health services and systems is Healthy Child Care Iowa funding, Title V and program income.

Hawki Outreach & Presumptive Eligibility		
Services	**Service Activities**	**Support Activities**
Presumptive Eligibility	For presumptive eligibility ● Explaining process and key timeframes to family	● Writing, updating and reviewing Presumptive Eligibility materials, policies procedures. ● Staff training related to Presumptive Eligibility

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	● Completing necessary forms ● Submitting information through MPEP ● Time documenting presumptive eligibility services	● Involving clients, families and priority populations in development of policy and procedures, review of materials and process for Presumptive Eligibility.
Enabling and Public Health Services & Systems	● Promotion and distribution of Hawki materials ● Partnerships with Department Programs ● Partnerships with community organizations ● Providing Hawki Outreach & Presumptive Eligibility to required populations	
Funding for Presumptive Eligibility is Hawki Outreach funds or MAF. Funding for Hawki Outreach is Hawki Outreach funds, MAF or program income.		

Direct Care		
Services	**Service Activities**	**Support Activities**
● Sign language or oral interpretive services for a direct care service ● Telephonic oral interpretive services for a	● Initial interview ● Medical and social history ● Client preparation ● Client assessment or examination, identification of related problems	● Reception ● Completion of intake forms ● Obtaining consent and release of information ● Contacting families to set up or remind them of agency appointments ● Accessing and using needed reports from MCAH data system ● Determination of payer status

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direct care service ● Developmental testing (ASQ) ● Emotional/ behavioral assessment (ASQ:SE) ● Nursing assessment ● Nutrition counseling ● Home visit made for nursing or social work services ● Depression screening for adolescents and also caregivers ● Domestic violence screening for adolescents and also caregivers	● Screening ● Plan of care ● Client education ● Client counseling, motivational interviewing ● Communication of results to medical home ● Referral to other sources of care including completion of forms and other communication ● Documentation in MCAH data system and in the medical record ● Documentation in HHLPSS, IRIS, etc.	● Quality assurance activities, including medical record audit and MCAH data system reviews. Pulling and analyzing clinic data reports ● Attending staff development or meetings related to these services ● Time for preparation for home visit (such as setting up appointment time, gathering supplies, reviewing plan of care, gathering educational materials needed, reserving vehicle) ● Disposal of infectious waste ● Staff travel time ● Preparation and tear down of space for clinical services such as gathering supplies, medical records, setting up room prior to clinics, between clients and at the end of the clinical day ● Attending staff development or meetings specifically related to laboratory services ● Obtaining medical orders ● Staffing and contingency plans

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● Alcohol and/or substance abuse screening with brief intervention for adolescents and also caregivers ● Annual alcohol screening ● Alcohol and/or substance abuse screening ● Behavioral counseling for alcohol misuse counseling ● Behavioral counseling for obesity ● Screening test of visual acuity (quantitative); instrument-based ocular screening		

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● Hearing screen - Speech audiometry or pure tone ● Preventive medicine counseling (related to testing for chlamydia and gonorrhea) ● Comprehensive health/well child screening exam (initial and periodic) ● Mental health assessment ● Hemoglobin ● Hematocrit ● Tuberculosis skin testing ● Venipuncture ● Capillary blood draw ● Lead testing		

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● Handling and conveyance of specimen for transfer to a laboratory ● Lead analysis ● Evaluation & Management ● Immunization administration and counseling ● Immunization administration only ● Initial & subsequent administration of immunization		
Funding for conducting direct care services (service, service activities and support activities) is program income, some Title V funds may be used for children who qualify for Title V only. MAF and Title V funds are not used to cover expenses not covered by reimbursement from third-party payors (including Medicaid, Medicaid MCOs) or private pay direct care services. Funding for giving immunizations (service, service activities and support activities) is program income.		

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Funding for conducting blood lead testing (service, service activities and support activities) is program income, some Title V funds may be used for children who qualify for Title V only.

Child Health Dental		
Services	**Service Activities**	**Considerations**
• Services to build public health system capacity • Costs associated with limited direct dental services by CAH staff for non-Medicaid enrolled children • Dental Vouchers	Examples of Public Health Services and Systems activities regarding oral health include: • Surveying dental offices to identify oral health care accessibility in the service area • Establishing regular, personal contact with dentists to advocate for children, pregnant people and families • Developing referral tracking systems with local dental offices	• CH Dental funds cannot be used to support direct care services provided within Federally Qualified Health Center (FQHC) dental clinics. • Contractors that use CH Dental funds to reimburse dentists for services must have a written agreement with those dentists. • All staff must be trained by I-Smile™ Coordinator prior to providing any direct oral health services.

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	• Educating and training physicians on oral health • Conducting MCAH staff trainings to develop oral health education, care coordination and referral protocols • Establishing relationships with school health staff to assure oral health education and prevention services • Developing and presenting oral health information for the board of health • Participating in the local Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP) process • Conducting strategic planning with local oral health coalitions and other forums to assess	

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	community oral health needs • Planning and implementing activities with community partners, such as “Give Kids a Smile Day” • Organizing open mouth surveys • Providing oral health education for Head Start parents or prenatal classes • Providing oral screenings at a community event (e.g. health fair) • Providing oral screenings for open mouth surveys • Providing gap-filling screenings for children unable to meet the school dental screening requirement	

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	• Promoting the importance of oral health • Sharing oral health information with local organizations that have interest in the health of women and children • Meeting with child care providers to evaluate and implement oral health programs • Coordinating the school dental screening requirement with local boards of health, schools and providers • Promoting early oral health care through hospital delivery centers, pediatricians and/or obstetrician/gynecologists Direct Services for non-Medicaid enrolled children: • Oral screening	

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	• Risk assessment • Fluoride varnish application • Dental sealant application • Silver diamine fluoride application • Prophylaxis • Radiograph • Oral hygiene instruction • Nutritional counseling for the control of dental disease • Tobacco counseling for the control of dental disease Dental Vouchers: • Reimbursement at Medicaid rates to local dentists to provide limited preventive and restorative dental service for Title V-eligible children and adolescents birth	

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Child Health Dental Funds may be used for any of the above activities/services as well as program income.

I-Smile™		
Services	**Service Activities**	**Considerations**
• Costs associated with building public health systems capacity, including assurance of population-based oral health services and non-billable enabling services, to develop local systems to assure dental access for Medicaid-enrolled children; and • Costs associated with maintaining a	I-Smile™ funds must be used for services to build public health system capacity that provide support for developing and maintaining comprehensive oral health service systems in communities, costs associated with building public health system capacity and assuring non-billable population-based oral health services. • Develop and build local partnerships in the community to increase awareness about oral health. • Address oral health issues of county residents through	• I-Smile™ funds cannot be used for any costs associated with the provision of direct dental services, including salaries of direct service staff for the time spent providing direct services or purchase of supplies for direct dental services. • Dental Care Coordination time for Medicaid enrolled children should be paid from MAF; dental care coordination time for non-Medicaid enrolled children may be paid from I-Smile™. • Time spent providing gap-filling direct services must be reimbursed using program income or CH Dental (Title V) funds; I-Smile™ grant funds may not be used for any direct services.

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dental hygienist as the I-Smile™ Coordinator, responsible for implementing the Contractor's I-Smile™ project activities and ensuring integration and completion of I-Smile™ strategies as part of the oral health program plan. • Local Boards of Health (LBOH) collaboration • Planning and Needs Assessment • Staff Training • School Screening Audits	linkage with local boards of health. • Establish dental referral networks using outreach visits to dental offices. • Ensure dental care coordination and referral services for families to facilitate dental visits for regular preventive and restorative care. • Conduct program planning and regular needs assessments. • Develop and maintain protocols and provide training to ensure competency of direct care, informing, and care coordination CAH staff regarding oral health. • Collaborate with the Maternal Health Contractor within the	

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• Partnership Development • Dental Referral Network • Medical Providers Outreach • OH promotion • Dental Care Coordination • Quality Assurance • Collaboration with the MH Coordinator	CSA to improve oral health and birth outcomes for low-income women, as well as ensure optimal oral health for their infants. • Provide outreach visits to medical providers to ensure they are aware of oral health as part of overall health. • Promote oral health, creating awareness and sharing oral health messages. • Ensure provision of gap-filling preventive dental services for underserved children by direct service staff, including implementation of the I- Smile™ @ School program Quality Assurance includes activities related to the I-	

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	Smile™ program and of documentation of services entered into the MCAH data system. This will include quarterly reports, chart audits, service note reviews, assuring accurate data entry using error reports from the MCAH data system.	
I-Smile™ grant funds may be used for any of the above listed activities. See MCAH Administrative Manual for additional examples.		

I-Smile™ @ School		
Services	**Service Activities**	**Considerations**
Implementing a school-based sealant program (including planning, personnel, supplies, travel) in a minimum of 2nd and 3rd grades with 40% or greater free/reduced lunch participation and/or eligibility for the	To ensure that all I-Smile™ @ School guidelines are followed and requirements are met, the DDSP will: • Assess School Eligibility • Complete the Program Workbook • Implement the Program: o Partner with local schools (e.g.,	• School must be at 40% or greater free/reduced lunch participation and/or eligibility for the Community Eligibility Provision (CEP) designation based on Iowa Department of Education data. • 2nd and 3rd grade students are required, but additional grades may be included. • Contractor must provide an oral screening to a minimum number of students per contract period in their CSA.

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Community Eligibility Provision (CEP) designation based on Iowa Department of Education data Funds may be used for costs associated with providing oral health classroom education to second and third-grade students.	schedule dates, distribute forms). o Use appropriate staff (Iowa-licensed dental hygienists, dental assistants, dentists when indicated). o Assure provision of direct services (screening, risk assessment, sealants, and fluoride varnish) to students with consent in participating schools (regardless of payer source). o Ensure that the minimum number of students have been screened each year (as determined by the Department).	• No more than 20% of I-Smile™ @ School grant funds may be used for time spent by staff to provide direct dental care. o For the purposes of the I-Smile™ @ School Program, direct service costs only include personnel time spent providing oral screenings and application of sealant and/or fluoride varnish (e.g., time “in the mouth”). • The I-Smile™ Coordinator will assure the implementation of the I-Smile™ @ School program through oversight of the (DDSP). • To avoid duplication of services, the I-Smile™ @ School program will NOT be implemented in schools that will be served by non-Department funded school-based sealant programs (e.g., Federally Qualified Health Center). • All Registered Dental Hygienists (RDH) and Registered Dental Assistants (RDA) must have Public Health Supervision Agreements in place that include CSA schools and applicable services.

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	o Offer students in second and third-grades the program services. Grades 1, 4, 5, 6, 7 and 8 may also be served. Contractors may request an exception to policy if additional grades are anticipated (e.g., kindergarten or 9th grade). o Provide classroom education, as able. • Follow Program Guidelines: o Use appropriate equipment, supplies, techniques and procedures. o Use I-Smile™ @ School outreach and promotion materials as	

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		directed throughout the project period. o Use standardized forms and materials. o Assure billing of services provided to Medicaid-enrolled students. o Assure provision of care coordination for children/adolescents identified with dental treatment needs by referring students to dental offices for care, assisting families in making appointments, assisting families in finding payment sources for care, and educating families about the need for good oral	

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		health and regular care. o Assure use of Medicaid Administrative Funds (MAF) for dental care coordination services provided for Medicaid-enrolled children, when applicable. o Assure data entry of all services and consent tracking into the Department's MCAH data system. o Attend meetings as required by the Department.	
I-Smile™ @ School grant funds may be used for any of the above listed activities. See MCAH Administrative Manual for additional examples.			

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	Health Equity & Family Engagement	Informing , Care Coordination, Medical Home	Immunization(Enabling and Public Health Services and Systems -- NOT DIRECT CARE)	Lead (Enabling and Public Health Services and Systems -- NOT DIRECT CARE)	Early ACCESS	Healthy Child Care Iowa	Hawki & Presumptive Eligibility	Direct Care	Child Health Dental	I-Smile™	I-Smile™ @ School Direct Care	I-Smile™ @ School Non-direct Care	TOTAL CAH Minutes	Total CAH Hours worked
Monday business hours	**0**	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Monday outside hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Tuesday business hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Tuesday outside hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Wednesday business hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Wednesday outside hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Thursday business hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Thursday outside hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Friday business hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Friday outside hours	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Saturday	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Sunday	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
TOTAL TIME	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**