IOWA | Health and Human Services

Number: 701-MH
Title: MH Medicaid Administrative Fund Services
Effective Date: 10/01/2022
Revision Date: 9/3/2025
Date of Last Review: 09/03/2025
Authority: Iowa Code § 135.11(17), Iowa Administrative Code 641 IAC 76 (135), Social Security Act Title V §§701-710, subchapter V, Chapter 7, Title 42.

Overview

Through a formal written agreement, DHS engages IDPH to provide care coordination, presumptive eligibility, and related interpretation services for Maternal Health (MH) clients. The Department fulfills this responsibility by contracting with local community-based programs to work with clients in collaborative service areas. This is an arrangement unique to Iowa. These services are paid through Medicaid Administrative Funds (MAF) associated with the written agreement. As a result, these services are frequently referred to as “MAF services”.

Policy

Contractors are responsible for providing the following services to pregnant and postpartum women enrolled in Medicaid:

1. Dental care coordination
2. Medical care coordination for clients not enrolled in Medicaid managed care (Fee-For-Service or FFS).
3. Presumptive eligibility.
4. Interpretation services pertaining to these listed services.

Contractors are also responsible for providing these services for pregnant and postpartum women eligible for Title V (see 10# Maternal Health Program Eligibility & Voluntary Participation):

1. Medical care coordination
2. Dental care coordination
3. Interpretation services pertaining to these listed services

Contractors are required to have policies and procedures outlining how staff are to provide these services.

Procedure

Staff skills and competencies needed to conduct Medicaid Administrative Funds (MAF) Services include:

1. Ability to effectively communicate information to all clients
2. Assess client needs and refer to appropriate providers
3. Understand factors that may influence the client's health beliefs
4. Engage in a personalized approach focused on client needs
5. Adapt services to accommodate client needs, such as language barriers or literacy levels
6. Understand Medicaid and Presumptive Eligibility for Pregnant Women programs
7. Ability to promote preventive care
8. Ability to promote medical and dental homes
9. Establish and maintain linkages with local primary care providers and community resources

Motivational interviewer training is required for all staff involved in providing MH services.

Medicaid Administrative Fund Billing

The activities required for effective care coordination, presumptive eligibility, and interpretation of those services may be included in a contractor's Medicaid Administrative Fund (MAF) billing to IDPH. MAF funds include all expenses and staff time spent doing presumptive eligibility, care coordination (including dental), and related Interpretation. For example, care coordination is not just the time in and time out spent talking, emailing, or texting with the client; the agency can bill for the time spent looking up numbers, searching through resources, and making calls that do not get answered. Expenses for printing, paper, phone service, and related expenses should also be included in the MAF monthly billing. In addition, these activities should be included in the time study – so the contractor may determine the full cost of services. Please be aware of the following exceptions to MAF billing:

1. If the purpose of a home visit is to provide direct care services, a home visit for care coordination cannot be billed.
2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Contractors may not bill child health care coordination for any part of this maternal health visit.

Required Resources for Implementation

1. Contractor-specific training on each service, policy, and procedures
2. Orientation and training on the statewide expectations, policies, and procedures for MAF services

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Number: 701-CAH
Title: EPSDT Program and Medicaid Administrative Fund Services
Effective Date: 10/01/2022
Revision Date: 09/02/2025
Date of Last Review: 09/02/2025
Authority: Iowa HHS Omnibus Agreement, Contract Special Conditions, Iowa HHS General Conditions for Service Contracts

Overview

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program provides comprehensive health care for Medicaid-enrolled clients under the age of 21. The EPSDT program was implemented in 1967 by the United States Congress. Every state's Medicaid program has an EPSDT Program; in Iowa, the program is also known as the EPSDT Care for Kids Program.

Contractors focus on activities of the EPSDT program, including informing, care coordination, Presumptive Eligibility (PE), and gap-filling screening, in order to assist clients in getting to their medical homes early and within the recommended time frames. Medical homes and specialists are primarily responsible for screening, diagnosis, and treatment. The acronym EPSDT stands for:

1. **Early**: Children should receive quality health care beginning at birth and continuing throughout childhood and adolescence, including the identification, diagnosis, and treatment of medical conditions as early as possible.
2. **Periodic**: Children should receive well-child visits at regular intervals throughout childhood and adolescence, according to the Iowa EPSDT Periodicity Schedule. Health care may be provided between regularly scheduled visits.
3. **Screening**: Children should be screened for health, developmental, and social-emotional concerns. Services should include health history, developmental and behavioral assessment, physical exam, immunizations, lab tests, nutrition/obesity prevention, OH exam, health education (anticipatory guidance), and vision and hearing screenings.
4. **Diagnosis**: Children should receive further evaluation of health, developmental, or social-emotional problems identified during well-child visits that may require treatment.
5. **Treatment**: Children should receive treatment for health, developmental, or social-emotional problems identified during well-child visits.

In Iowa, Iowa HHS administers the Iowa Medicaid Program and, therefore, is the administrative agency for the EPSDT program. Iowa HHS engages Title V contractors to provide EPSDT Informing, care coordination, Presumptive Eligibility, and related interpretation services for eligible clients. This is an arrangement unique to Iowa. The services of Informing, care coordination, and presumed eligibility, as well as the interpretation and transportation services, are paid through Medicaid Administrative Funds (MAF). As a result, these services are frequently referred to as "MAF services" in the CAH program and as they form the bulk of the Enabling level of the MCH Pyramid and may also be referred to as enabling services.

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Authority: Iowa HHS Omnibus Agreement, Contract Special Conditions, Iowa HHS General Conditions for Service Contracts

Policy

Contractors are responsible for providing the following services to clients 0 to 21 years of age enrolled in Medicaid:

1. Informing for all newly Medicaid-enrolled clients
2. Dental care coordination
3. Medical care coordination for clients not enrolled in Medicaid-managed care (Fee-For-Service or FFS)
4. Well-visit reminders for clients served in the past two years who are in the Maternal Health (MH) and Child and Adolescent Health (CAH) data system “Agency Home.”
5. Presumptive eligibility
6. Interpretation services pertaining to these listed services

Contractors are also responsible for providing these services for clients 0 to 22 years of age eligible for Title V (see Policy 106 Child & Adolescent Health Program Eligibility & Voluntary Participation):

1. Medical care coordination
2. Dental care coordination
3. Well-visit reminders for clients served in the past two years who are in the MCAH data system “Agency Home.”
4. Interpretation services pertaining to these listed services
5. Transportation services pertaining to these listed services

Contractors are required to have policies and procedures outlining how staff are to provide these services.

Procedure

Staff skills and competencies needed to conduct the required EPSDT/Medicaid Administrative Funds (MAF) Services include:

1. Cultural and linguistic competence to communicate the information in a meaningful way to all clients
2. Relate to clients to encourage involvement in EPSDT services
3. Assess client needs and refer to appropriate providers
4. Understand the impact of the client’s culturally-related health beliefs
5. Engage in a client/family-centered, strength-based approach
6. Tailor informing services to address client choices, preferences, and special needs such as language barriers, low literacy levels, etc.

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7. Understand Medicaid and EPSDT programs, including the Iowa EPSDT Periodicity Schedule and dental periodicity schedule
8. Understand immunization schedules for birth to 21 years old from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP)
9. Ability to promote preventive care, including immunizations
10. Ability to promote medical and dental homes
11. Knowledge of and ability to explain child and adolescent growth and development
12. Establish and maintain linkages with local primary care providers and community resources
13. Motivational interviewer training is encouraged for all staff involved in providing EPSDT services.

Medicaid Administrative Fund Billing

The activities required for effective Informing, care coordination, Presumptive Eligibility, and interpretation and transportation of those services may be included in a Contractor's MAF billing to Iowa HHS. MAF funds include all expenses and staff time spent doing Informing, Presumptive Eligibility, care coordination (including dental), and related Interpretation and transportation. For example, care coordination is not just the time spent talking, emailing, or texting with the client; Contractors can bill for the time spent looking up numbers, searching through resources, and making calls that do not get answered, etc. Expenses for printing, paper, phone service, etc., should also be included in the MAF monthly billing. In addition, these activities should be included in the time study – so the contractor may determine the full cost of services. Please be aware of the following exceptions to MAF billing:

1. If the purpose of a home visit is to provide direct care services, a home visit for care coordination cannot be billed.
2. The entirety of the maternal health postpartum home visit is part of the maternal health services. Any care coordination on behalf of the baby is considered part of this postpartum visit. Do not bill the CAH program for care coordination for any part of this maternal health visit.

Required Resources for Implementation

1. Contractor-specific training on each service, policy, and procedures
2. Orientation and training on the statewide expectations, policies, and procedures for MAF services

Resources

Iowa HHS General Conditions for Service Contracts

Number: 702
Title: CAH Informing Services
Effective Date: 10/01/2022
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Date of Last Review: 09/03/2025
Authority: HHS Omnibus Agreement; CMS Medicaid Manual

Overview
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program provides comprehensive health care for Medicaid-enrolled clients under the age of 21. According to the federal Centers for Medicare and Medicaid Services (CMS), there are two important features of the EPSDT program: assuring the availability and accessibility of required healthcare resources and helping Medicaid clients use these resources.

Through the process of "informing", the family is provided information about the services they are eligible for that are covered under Medicaid (i.e., the variety of medical, dental, and support services). The purpose of informing is to educate and assist the client in understanding their Medicaid benefits and the importance of preventive medical and oral health care to improve client health outcomes throughout their life.

Policy
Contractors shall use clear and nontechnical language to provide a combination of written and oral methods to inform all eligible clients effectively describing what services are available under the EPSDT program, the benefits of preventive health care, where the services are available, that they are available at no cost to the family, how to obtain them; and that necessary transportation and scheduling assistance is available.

Contractors shall provide quality Informing services for each newly enrolled Medicaid client from birth to 21 years of age in each county of the collaborative service area (CSA). Informing services shall be completed within 30 days of receiving the client informing list and completed each month of the year. Contractors shall notify the Department in writing within ten (10) calendar days of any circumstances that impact the Contractor's ability to provide the required Informing services.

Required Resources for Implementation
EPSDT Informing training

Procedure
Contractors shall:

1. Provide all three steps of the Informing service, including Initial Inform, Inform Follow-ups (if necessary), and Inform Completion.

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2. Develop and annually review Contractor policies and procedures to ensure the Informing services are meeting the needs of clients/families. Policies and procedures shall include detailed information on all three required steps of the Informing process and be consistent with Department guidelines.
    a. Clients and family members of the CSA, clients/family members eligible for Informing, and clients/family members from populations with less access to healthcare services shall be included in the development and review of the policies and procedures regarding Informing, call/text scripts, and the contents of the Informing packet. Clients/families will be engaged to make recommendations for policy/procedures related to connecting with families, providing input on how families are communicated with, how to communicate information, and ensuring processes and information are family-centered.
    b. Develop and annually review age-specific Informing scripts that comply with Department guidelines to be used when contacting clients. Ensure call and text scripts are vetted for relevance and understanding by clients/families.
    c. Develop and annually review a county-specific resource directory for clients/families. The development and annual review of the resource directory should include clients and family members of the CSA, clients/family members eligible for Informing or other CAH program services, and clients/family members from populations with less access to healthcare services. The resource directory must meet the following criteria:
        i. Include county-level resources for the county of residence of the client/family. The Contractor may opt to include regional, state, and national resources.
        ii. Contain medical and dental providers taking Medicaid clients in the client's/family's county of residence.
        iii. All resources must be verified by the contractor at the time of review. Resources must include pertinent information such as location, hours of operation, and contact information, but should strive to provide more detailed information (e.g., Food Pantry: fresh fruit is available on the first Tuesday of the month, food often runs out by noon; Provider X speaks Spanish, etc.).

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iv. Contain information relevant to the health and social determinants of health (SDOH) for clients age birth to 21 years. Do not include a listing of businesses/organizations in the county that do not offer Health/DOH services to CAH clients; the listings should be relevant to the clients/families this program serves.

3. Provide informed services in the primary language of the client. Provide interpretation services to inform when needed (see Policy 708 Interpretation Services).
4. Coordinate care and facilitate access to community resources for clients/families based upon needs identified by them during the Informing process.
5. Engage in ongoing quality assurance and quality improvement activities related to Informing.
6. Document all Informing services provided by the Contractor or through subcontractors at the time of service and be made available to Iowa HHS by the 15th of the month following the month of service.
7. Check the Medicaid eligibility status of clients using the Iowa Medicaid Enterprise (IME) Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639 or online through the IME ELVS Web Portal.

Initial Inform:

1. In the first week of every month, Contractors shall utilize a monthly Informing list filtered from the MCAH data system to identify all children/families eligible for the Informing service in their CSA. The report will give the child's name and contact information so the informing process can begin.
    a. Informing services are provided for the family unit rather than an individual client. Some clients have never before received Medicaid benefits, while others may have received them in the past. Any client who becomes eligible again after being off Medicaid for the previous 90 days or more is considered to be newly eligible and shall receive Informing services.
    b. Clients must be informed within 30 days of receiving the monthly Informing list. The month of June must be completed by the 30*th* of the month due to the end of the State Fiscal Year.
2. Contractors shall complete Initial Informing by mailing an introductory packet to the families of all newly enrolled Medicaid clients from birth to 21 years. This

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mailing shall include an initial welcome letter, Medicaid EPSDT brochure, I-Smile™ information, age-appropriate preventive health care education, and community resources that address social determinants of health (e.g., health care providers and dentists accepting Medicaid, food pantries, Child Care Resource and Referral, mental health resources, etc.). The packet shall include contact information for the Contractor and let the client know that the Contractor will be attempting to reach the family.

3. Contractors shall include the days and hours families can expect contacts to be made and when the Contractor has staff available to answer contacts from the family, including those outside normal business hours (8:00 a.m. - 4:30 p.m. M-F). Families have expressed that specificity about how and when to expect contacts will ensure better outcomes.

Inform Follow-Up:

1. Inform Follow-ups are attempts to conduct an Inform Completion.
2. Contractors shall complete informal follow-ups by making phone, text, and/or face-to-face attempts to reach the client/families with the goal of having a dialogue about the benefits available to them through Medicaid. Inform Follow-ups are required to use the following methods:
    a. A minimum of two attempts to contact the client/family must be made on different dates/times during the 30 days. These hours must:
        i. It consists of staff actively making contact attempts and being available live to answer calls/texts and/or in-person visits.
        ii. Be communicated in the Initial Inform packet as times the client/family can expect calls, texts, or visits and that staff will be available to return calls and texts. Therefore, the hours must be scheduled in advance.
3. Contractors must make at least one attempt by live phone call or an in-person visit. Additional phone calls may be made, including the use of technology-assisted calling. However, the option to be easily routed to a live person for Inform Completion must be available when the technology-assisted calls are made.
4. Contractors may utilize text messaging provided that such messaging is HIPAA compliant and follows HHS guidance. Texting may be used to encourage the family to contact the Contractor (as an inform follow-up attempt) or accept the Contractor's call (pre-text). No protected health information (PHI) shall be

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included in texts. Appropriate use of texting for Inform Follow-ups would be similar to: “This is Mandy with (Name of Contractor); I am trying to reach you to discuss important information about your child’s Medicaid coverage (or health insurance). Please call me at (phone number)” or “I will be attempting to call you from this number.” Texts must be sent from a Contractor-owned device. No personal devices may be used.

5. If a phone number in the MCAH data system does not work, the Contractor shall attempt to locate a phone number through other resources, including collaboration with other entities (such as WIC).
6. If the client cannot be reached by the above requirements, a follow-up written communication must be sent reinforcing components of the EPSDT program, encouraging the use of preventive health care, and containing Contractor contact information. A follow-up postcard may be mailed; however, postcards may not contain PHI, and postcards must comply with state and federal laws, HIPAA, and Department guidelines.
7. If repeated attempts to reach the client are unsuccessful, the Contractor may elect to release ownership of the client per Department and Contractor guidelines. Do not mark it as ‘unsuccessful’; instead, leave the client open in case of future contact. The client will automatically be closed by the MCAH data system after 12 months.

Inform Completion:

1. Contractors shall conduct Inform Completion by having a conversation that includes the benefits of establishing a medical and dental home, the comprehensive array of services available through Medicaid, including interpretation and transportation resources, the benefits and importance of preventive care, how and where Medicaid benefits can be used, and resources available in the community to address the social determinants of health. The following topics are to be discussed:
    a. How managed care and managed care assignments work, and the right to switch managed care companies.
    b. How to select a primary care provider with MCO coverage and the right to switch assigned primary care providers.
    c. Federal rules mandate that clients have the freedom to choose their health care/dental providers. To comply with these rules, Contractors must be

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prepared to discuss provider options with each client. Clients enrolled in Medicaid have the ability to choose a provider under their Medicaid status (Fee-for-Service or managed care). Clients must be informed of the financial consequences of choosing a non-Medicaid provider since Medicaid will not pay for services given by a non-Medicaid provider. A client's choice of a non-Medicaid provider should not be considered a refusal of services.

d. Where screening services are available and how to obtain them.
e. Encouraging and assisting the family to establish medical and dental homes for their children.
f. Support services available through the EPSDT program (such as transportation, translation, interpretation, and early care and education (ECE)).
g. Community resources needed to meet social determinants of health needs of the client/family.
h. All Medicaid-eligible clients have the right to appeal Medicaid decisions. Information on filing an appeal can be found on the HHS Appeal webpage. Clients who have questions specific to the appeal process may contact their HHS worker or the HHS Appeals Section at 515-281-3094. Clients wishing to appeal may also wish to contact an attorney or Iowa Legal Aid at 1-800-532-1275. In Polk County, clients may call 515-243-1193.

2. Contractors shall use clear and nontechnical language and provide a combination of written and oral methods to inform all eligible clients effectively describing what services are available under the EPSDT program, the benefits of preventive health care, where the services are available, how to obtain them; and that necessary transportation and scheduling assistance is available.
3. The goal for Inform Completions in each CSA is 70%.
4. Contractors may determine additional ways to successfully reach clients/families. Contractors are encouraged to work with clients/families and populations with less access to healthcare services to determine additional or new ways to reach families, including partnerships with community organizations that are trusted and utilized by families.

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Personnel:

1. Contractors are required to designate employees to carry out informing services. Staffing is dependent upon the number and needs of clients in the CSA. Staff need the following competencies to provide the Informing service:
    a. Communicate complex information in an understandable way using plain, non-technical language with clients. Utilize the client's primary language. Engage a qualified interpreter when needed (see Policy 708 Interpretation Services).
    b. Relate to clients to encourage involvement in preventive health care and to assess client needs and barriers.
    c. Be knowledgeable of community resources and refer to appropriate providers to meet client needs.
    d. Tailor Informing services to address client choices, preferences, and special needs such as language barriers, low literacy levels, and hearing or sight impairment.
    e. Understand the Medicaid program, including components of Iowa's Periodicity schedule.
    f. Understand the CDC and ACIP Childhood Immunization Schedules and be able to communicate the schedule to clients.
    g. Understand and explain child and adolescent growth and development.
    h. Establish and maintain linkages with local providers and community resources.
2. Develop and maintain a comprehensive contingency plan to provide informing services in the event of staff vacancies and emergency situations. The contingency plans must be fully operational and implemented within ten business days of a vacancy or emergency event. The plan shall include provisions for technology failure and inaccessibility (e.g., building flood/fire/unsafe structure, facility relocation, system hacking, etc.) and assures adequate staffing to provide the Informing service to all eligible clients every month of the year.
3. All staff, including subcontractors, performing the Informing process shall be trained on and have access to the Informing scripts, policies, and procedures, which shall include guidance on documentation of the Informing process in the MCAH data system.
4. See Policy 201 Required Personnel for additional requirements related to personnel.

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Documentation
Contractors must document each step of the Informing process in the MCAH data system for each newly eligible client in the family. The MCAH data system User Manual in the Document Library of the MCAH data system provides specific guidelines for documenting services.

Resources
CMS Medicaid Manual
IME ELVS Web Portal
CDC and ACIP Childhood Immunization Schedules
Iowa's Periodicity schedule
HHS Appeal website

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Number: 703-MH
Title: MH Care Coordination (Medical, Dental, Home Visit, Transportation, Interpretation)
Effective Date: 10/01/2022
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Date of Last Review: 09/03/2025
Authority: Omnibus Agreement

Overview

The Title V program encourages clients to have medical and dental homes for continuity of care and ensures pregnant and postpartum women have an obstetrical (OB) provider for their pregnancy. Care coordination services help clients to:

1. Overcome barriers to access health care
2. Become independent health consumers
3. Adopt healthy habits
4. Make informed healthcare choices
5. Establish and maintain medical homes and dental homes
6. Improve their health, mental and physical well-being

Specific care coordination activities will depend on the needs and preferences of the client. The following list contains some of the possible activities:

1. Assisting clients in accessing prenatal or postpartum care
2. Assisting in establishing medical and dental homes
3. Assisting with scheduling appointments (outside of the Contractor agency)
4. Assisting the client to prepare a list of questions or concerns prior to the medical or dental visit
5. Following up to make sure the client received the care intended at the appointment
6. Following up to reschedule missed appointments
7. Assisting clients when referral for further care is needed
8. Arranging support services such as transportation to Medicaid providers or interpreter services
9. Monitoring medical and dental care plans
10. Linking clients to other health-related community services

Policy

Contractors shall actively locate (not relying solely on clients/families self-identifying as needing care coordination) and provide care coordination to Title V clients, clients during the Presumptive Eligibility period, and clients enrolled in Medicaid Fee-For-Service (FFS) (clients not enrolled in a Managed Care Organization).

Procedure

1. Contractors shall develop and annually review policies/procedures and assure they are consistent with Department guidelines for care coordination. Contractors shall assure

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policies/procedures regarding documentation of care coordination in the MCAH data system follow required Department guidelines.

2. Care coordination shall include the following core elements related to Title V:
   a. Assessment of medical and dental home, and assistance in establishing a medical or dental home if there is no current medical or dental home.
   b. Assessment of barriers to attending prenatal care or dental appointments
3. Follow up medical and dental care coordination to previous care coordination within 30 days, does not require the re-assessment of each of these elements. Professional judgment and circumstances guide reassessment during follow-up care coordination. Note in the documentation that the service is a follow-up care coordination.
4. If conducting targeted care coordination of an immediate need, assist the family as needed to meet their need. Pursue full medical and dental care coordination to assess core care coordination and assist with those needs, once the family's immediate need is met.
5. Contractors shall assist clients/families with health literacy by assessing their needs and then structuring education based on those needs to help them understand how insurance works, how to make appointments, how to obtain referrals or specialty care, the importance of preparing questions for the primary care provider, etc. In addition, it helps clients understand changes in coverage and processes involved in transitioning from one type of coverage to another. Provide additional education or assistance in understanding health literacy, as needed.
6. When providing care coordination for postpartum clients, the client's insurance status must be assessed to determine if they will lose coverage 12 months following the birth of their baby. If the client loses coverage, the contractor shall assist them in identifying alternate coverage, such as through the Health Insurance Marketplace, and educate the client on the importance of a well-woman visit.
7. Contractors shall build a referral network throughout the CSA of OB care providers to serve as medical homes for Title V clients, clients during the Presumptive Eligibility period, and clients enrolled in Medicaid Fee-For-Service. If the Contractor is a medical home or part of a system that serves as a medical home, the referral network must include providers outside their organization to provide choice to clients. Contractors shall provide equal opportunity to choose another organization for services, with equal support and assistance, regardless of which provider is chosen.
8. Contractors shall build a referral network of community resources to assist clients with additional needs throughout the CSA.
9. Contractors shall provide care coordination in the primary language of the client and provide interpretation services for care coordination when needed. See 708 Interpretation Services Policy.
10. Contractors shall engage in ongoing quality assurance and quality improvement activities related to the care coordination process and documentation of care coordination entered into the MCAH data system.

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11. Care coordination services are conducted via phone, back and forth text or email or face-to-face (in person or via technology) dialogue with Medicaid clients to assist them with Medicaid related services such as medical, dental, mental health, transportation, and specialty care.
12. Leaving a message, sending a text without a response from the client, or mailing information is not care coordination.
13. As long as Medicaid-related services/programs are addressed, linkage to non-Medicaid resources (such as child care, WIC, parenting programs, social services, legal services, food, clothing, housing, and shelter services) may also be included in the time spent with the client.
14. Contractors must have agency-specific protocols that are consistent with Department guidelines for providing care coordination. Care coordination staff, clients, family members, and priority population insights are important to guide the Contractor in making appropriate changes to services, protocols, and educational materials.
15. Ensure materials are clear and understandable for the client.
16. Contractors shall assist with arranging local transportation to Medicaid-covered services for Medicaid Fee-For-Service clients, including clients during the Presumptive Eligibility period. Contractors can bill Medicaid for the transportation cost, and utilize Medicaid Administrative Funds to cover the care coordination.
17. Contractors shall arrange local transportation for Title V clients. Title V grant funds cover care coordination and transportation expenses.
18. Clients enrolled in a Medicaid MCO may be referred to their MCO for care coordination services. See 601 Managed Care Organizations Policy

Care Coordination Home Visit for a Medically Necessary Condition

1. Most care coordination activities will involve talking to clients on the telephone or at the Contractor's office, clinic setting, or approved telework site. However, a Contractor must be prepared to provide home visits to clients when needed.
    a. A home visit may be needed/indicated for a client who requires medically necessary care coordination for a health-related condition. Such necessity may include clients that lack phone service or are otherwise hard to reach.
    b. Provide information about available medical services.
    c. Assist the client in making and coordinating appointments, barrier removal, and access to care.
    d. Utilize referral network to assist clients in accessing services and social determinants of health

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Personnel

1. Contractors are required to designate employees to carry out care coordination services. Staffing is dependent upon the number and needs of clients in the CSA. Staff need the following competencies to provide the care coordination service:
   a. Communicate complex information in an understandable way using plain, non-technical language with clients. Utilize the client's primary language. Engage a qualified interpreter when needed.
   b. Relate to clients to encourage involvement in preventive health care and to assess client needs and barriers.
   c. Be knowledgeable of community resources and refer to appropriate providers to meet client needs.
   d. Adapt care coordination to accommodate client needs, such as language barriers or disabilities.
   e. Understand the Medicaid program
   f. Establish and maintain linkages with local providers and community resources.
2. Contractors shall train staff including subcontract staff and other staff who provide services to MH clients in the care coordination and in utilizing the MCAH data system to document care coordination in compliance with Department guidelines.
3. All staff, including subcontractors, performing care coordination shall be trained on, and have access to the resource directory, referral network, policies, and procedures which shall include guidance on documentation care coordination in the MCAH data system.
4. All staff, including subcontractors performing care coordination, shall be trained in motivational interviewing techniques.

See 201 Required Personnel Policy for additional requirements related to personnel.

Documentation

1. Contractors must document care coordination in the MCAH data system. The MCAH data system User Manual in the Document Library of the MCAH data system provides specific guidelines for documenting services.
2. For targeted follow up care coordination notes that do not involve coordinating medical/dental care, the date of the last well visit, name of provider, and assessment of immunization status is not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.
3. If care coordination is provided for multiple clients in the family, document the care coordination in each client's record in the MCAH data system.

Number: 703-CAH
Title: Care Coordination (Medical, Dental, Home Visit, Transportation, Interpretation)
Effective Date: 10/01/2016
Revision Date: 09/03/2025
Date of Last Review: 09/03/2025
Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

Overview

The Title V program is a medical home model and seeks to assure that the client's overall health is improved through care coordination to a medical home and to meet the social determinants of health (see Policy 105 Admission to CAH Services). Care coordination enables clients to:

1. Overcome barriers to access health care
2. Become independent health consumers
3. Develop healthy beliefs, attitudes, and behaviors
4. Make informed healthcare choices
5. Establish and maintain medical and dental homes
6. Improve their health and mental and physical well-being
7. Address social determinants of health

Specific care coordination activities will depend on the needs and preferences of the client. The following list contains possible care coordination activities:

1. Assisting clients in accessing periodic well-child screenings and dental screenings
2. Assisting in establishing medical and dental homes
3. Assisting with scheduling appointments (outside of the Contractor's organization)
4. Assisting the client to prepare a list of questions or concerns prior to the medical or dental visit
5. Following up to make sure the client received the care intended at the appointment
6. Following up to reschedule missed appointments
7. Assisting clients when referral for further care is needed
8. Arranging support services such as transportation to Medicaid providers or interpreter services
9. Establishing and implementing a plan(s) of care

Policy

Contractors shall actively locate and provide care coordination to clients enrolled in Title V**,** clients during the Presumptive Eligibility (PE) period, and clients enrolled in Medicaid Fee-For-Service (FFS) (clients not enrolled in a Managed Care Organization (MCO)). The contractor will provide care coordination to all clients when providing a gap-filling direct health care service.

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Revision Date: 09/03/2025
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Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

Procedure

1. Contractors shall develop and annually review policies/procedures and ensure they are consistent with Department guidelines for care coordination; contractors shall ensure policies/procedures regarding documentation of care coordination in the Maternal Health (MH) and Child Adolescent Health (CAH) data system follow required Department guidelines.
2. Contractors shall develop a plan for actively locating eligible clients who would benefit from care coordination. Contractors shall include ways to identify eligible clients for care coordination that are in addition to clients self-identifying as needing care coordination, care coordination associated with the provision of gap-filling direct health care services, and clients during the PE period.
3. Contractors shall include the following core elements related to Title V in care coordination:
    a. Assistance in establishing a medical or dental home if the client does not have one.
    b. Assessment of immunization status (see Policy 602 Immunization Access and Promotion).
    c. Assistance in accessing any missing ACIP recommended vaccines.
    d. Assessment of whether the child is current on well visits and dental screenings.
    e. Assistance accessing a well visit and/or dental screening if due/overdue.

Follow-up medical and dental care coordination to previous care coordination within 30 days does not require the re-assessment of each of these elements. Professional judgment and circumstances guide reassessment during follow-up care coordination. If it has been more than 30 days since the last contact or assessment of these core elements, reassess for additional care coordination needs related to these core elements. Note in the documentation that the service is a follow-up care coordination.

If conducting targeted care coordination of an immediate need, assist the family as needed to meet their need. Pursue full medical and dental care coordination to assess core care coordination and assist with those needs once the family's immediate need is met.

4. Contractors shall assist clients/families with health literacy by assessing their needs and then structuring education based on those needs to help them understand how insurance works, how to make appointments, how to obtain referrals or specialty care, the importance of preparing questions for the primary care provider, etc. In addition, it helps clients understand changes in coverage

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and processes involved in transitioning from one type of coverage to another. Provide additional education or assistance in understanding health literacy for populations with less access to healthcare services, as needed.

5. Contractors shall build a referral network throughout the CSA of primary care providers to serve as medical homes, provide screening services and comprehensive well-child visits to Title V clients, clients during the Presumptive Eligibility period, and clients enrolled in Medicaid Fee-For-Service. If the Contractor is a medical home or part of a health system that serves as a medical home, the referral network must include providers outside their organization to provide choice to clients. Contractors shall provide equal opportunity to choose another organization for services, with equal support and assistance, regardless of which provider is chosen.
6. Contractors shall build a referral network of community resources to meet clients' social determinant health needs throughout the CSA.
7. Contractors shall provide care coordination in the client's primary language. Provide interpretation services for care coordination when needed (see Policy 709 Interpretation Services).
8. Contractors shall engage in ongoing quality assurance and quality improvement activities related to the care coordination process and documentation of care coordination entered into the MH and CAH data system.
9. Care coordination services are conducted via phone, back and-forth text or email, or face-to-face (in person or via technology) dialogue with Medicaid clients to assist them with Medicaid-related services such as medical, dental, mental health, transportation, Child Health Specialty Clinics (CHSC), AEA, etc.
10. Leaving a message, sending a text without a response from the client, or mailing information is not care coordination.
11. As long as Medicaid-related services/programs are addressed, linkage to non-Medicaid resources (such as early care and education (ECE), WIC, parenting programs, social services, legal services, food, clothing, housing, and shelter services) may also be included in the time spent with the client.
12. Contractors must have agency-specific protocols that are consistent with Department guidelines for providing care coordination. Care coordination staff, clients, family members, and populations with less access to healthcare services insights are important to guide the Contractor in making appropriate changes to services, protocols, and educational materials.
13. Contractors shall ensure materials are at an appropriate reading level and culturally appropriate for the client.

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Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

14. Contractors shall assist with arranging local transportation to Medicaid-covered services for Medicaid Fee-For-Service clients, including clients during the Presumptive Eligibility period. Contractors can bill Medicaid for transportation costs and utilize Medicaid Administrative Funds to cover care coordination.
15. Contractors shall arrange local transportation for Title V clients. Title V grant funds cover care coordination and transportation expenses.
16. Clients enrolled in a Medicaid MCO may be referred to their MCO for care coordination services (see Policy 601 Managed Care Organizations).
17. Children with special health care needs may be referred to CHSC for specialized care coordination. CHSC staff are skilled in coordinating client-centered care that is effective, convenient, and offers informed options to families.
18. See Policy 906 Dental Care Coordination for additional information on dental care coordination.

Care Coordination Home Visit for a High Blood Lead or Medically Necessary Condition

1. Most care coordination activities will involve talking to clients on the telephone or at the Contractor's office, clinic setting, or approved telework site. However, a Contractor must be prepared to provide home visits to clients when needed.
    a. A home visit may be needed/indicated for a client who requires medically necessary care coordination for a health-related condition. Such necessity may include clients that lack phone service or are otherwise hard to reach.
    b. Provide information about available medical services.
    c. Assist the client in making and coordinating appointments, removing barriers, and accessing care.
    d. Utilize referral network to assist clients in accessing services and social determinants of health.
2. Each client with a blood lead level equal to or above 15 micrograms per deciliter (mcg/dL) must receive a skilled nursing visit. An RN may follow up on this high blood lead level by making a care coordination home visit to:
    a. Assess the client's knowledge of lead poisoning and instruct the client regarding nutrition, cleaning, and other relevant issues.
    b. Evaluate the home for other children living or visiting routinely and, if appropriate, make arrangements for testing of those children.
    c. Assist the client in making and keeping follow-up appointments.
    d. Remind the family to notify the client's lead program case manager if the family moves.

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e. Remind the family to inform the client's current and future healthcare providers of the elevated lead level and any subsequent tests that may demonstrate a lower blood lead level.
f. See Policy 604 Prevention and Early Intervention for Lead Poisoning and Iowa HHS Childhood Lead Poisoning Prevention Program for more information on blood lead poisoning in children.

Personnel

1. Contractors are required to designate employees to carry out care coordination services. Staffing is dependent upon the number and needs of clients in the CSA. Staff need the following competencies to provide the Care Coordination service:
    a. Communicate complex information in an understandable way using plain, non-technical language with clients. Utilize the client's primary language. Engage a qualified interpreter when needed.
    b. Relate to clients to encourage involvement in preventive health care and to assess client needs and barriers.
    c. Be knowledgeable of community resources and refer to appropriate providers to meet client needs.
    d. Tailor care coordination to address client choices, preferences, and special needs such as language barriers, low literacy levels, culture, and hearing or sight impairment.
    e. Understand the Medicaid program, including components of Iowa's Periodicity schedule.
    f. Understand the CDC and ACIP Childhood Immunization Schedules for birth through 18 year olds and be able to communicate the schedule to clients.
    g. Understand and explain child and adolescent growth and development.
    h. Establish and maintain linkages with local providers and community resources.
2. Contractors shall train all staff and subcontractor staff who provide services to CAH clients in care coordination and in utilizing the MH and CAH data system to document care coordination in compliance with Department guidelines.
3. All staff, including subcontractors, performing care coordination shall be trained on and have access to the resource directory, referral network, policies, and procedures, including guidance on documenting care coordination in the MH and CAH data system.

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Title: Care Coordination (Medical, Dental, Home Visit, Transportation, Interpretation)
Effective Date: 10/01/2016
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Authority: Iowa HHS Omnibus Agreement, Iowa HHS Childhood Lead Poisoning Prevention Program

4. All staff, including subcontractors performing care coordination, shall be trained in motivational interviewing techniques.
5. See Policy 201 Required Personnel for additional requirements related to personnel.

Documentation

1. Contractors must document care coordination in the MH and CAH data systems.
2. For targeted follow-up care coordination notes that do not involve coordinating medical/dental care, the date of the last well visit, provider name, and immunization status assessment are not required. Indicate in the note if it is a follow-up care coordination service. Address any additional family needs.
3. If care coordination is provided for multiple clients in the family, document the care coordination in each client's record in the MH and CAH data system.

Resources

Iowa HHS Childhood Lead Poisoning Prevention Program
CDC and ACIP Childhood Immunization Schedules for birth through 18 year olds
Iowa's Periodicity schedule.

Number: 704-MCAH
Title: Presumptive Eligibility for Medicaid for Pregnant Women and Children
Effective Date: 01/01/2024
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Overview

Presumptive Eligibility (PE) provides full Medicaid coverage for a limited time while the Iowa Department of Health and Human Services (HHS) makes a formal Medicaid eligibility determination. The goal of the PE process is to offer immediate health care coverage to individuals "presumed" to be eligible for Medicaid before there has been a full Medicaid determination. The presumptive period lasts until a formal determination is made (enrollment or denial), the application is withdrawn, or until the last of the month following the date of application.

Policy

Contractors shall assist clients in accessing Presumptive Eligibility (PE) through enabling services and the public health services and systems. The Department understands that on occasion Maternal Health (MH) agencies or Child Adolescent Health (CAH) agencies may be assisting with PE applications during work with a specific client in their population who has a family member identified to be in need of PE assistance as well. It is the goal of Iowa HHS to decrease barriers to accessing care and streamline services for individuals seeking services. Therefore, the following policy procedure guidance is available to support MH and CAH agencies who may be working in some capacity with overlapping families, in order to decrease duplication of service provision and support the 'no wrong door approach' for those seeking assistance. It is not intended to encourage agencies to routinely advertise, promote, or target PE services to the population not typically served by their respective agency. To be eligible for PE, the child, adolescent, caregiver, and/or parent must be an Iowa resident and a U.S. citizen or lawful permanent alien and meet income requirements. Only one PE application may be completed in any 12-month period. To be eligible for PE, the pregnant woman must be an Iowa resident and meet income requirements. A PE application may be done for each pregnancy and is not limited to the 12-month period.

Procedure

1. Staff at the contracted agency will complete the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request (Form 470-5201) and participate in web-based training through the Iowa Department of Health and Human Services. Only a trained QE is allowed to do PE determinations for Maternal Health and Child Adolescent Health clients.

Number: 704-MCAH
Title: Presumptive Eligibility for Medicaid for Pregnant Women and Children
Effective Date: 01/01/2024
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

2. All agencies employing QE staff must be annually approved by the Iowa Department of Health and Human Services as a Presumptive Provider (PP).
3. MH and CAH agencies can choose for the agency to be approved as the PP to provide PE for any of the following categories: Pregnant women, Children, and Hospitals (includes: former foster care children, individuals 19-64 years old, parents and caretakers, children, pregnant women). If the agency is approved as a PP in the hospital category, only clients who meet the definitions of the MH or CAH populations may be billed to MAF for reimbursement.
4. The QE will use the Medicaid Presumptive Eligibility Portal (MPEP) for presumptive Medicaid eligibility determinations. The QE will ask the families the required information from the Medicaid Presumptive Eligibility Portal (MPEP) or paper applications may be completed. The paper application is the Application for Health Coverage and Help Paying Costs (form 470-5170) and the Addendum to Application for Presumptive Eligibility (form 47-5192).
5. The QE will submit all information into MPEP. It is important to obtain all necessary information required through MPEP and try not to leave any blanks if possible.
    a. A social security number is not required for pregnant clients. For MH clients who do not meet citizenship requirements for full Medicaid coverage, the PE application should **not** be submitted for ongoing Medicaid coverage.
    b. To be eligible for PE, the client's family income must be below 215% of the Federal Poverty Level (FPL). Household size includes the unborn child.
    c. The number of babies expected by a pregnant person is not marked as required, however the application will be denied if this is not entered correctly (needs to be at least 1).
    d. A social security number is required for the child, but not the parent. If a parent is undocumented or does not have a SSN, the application will not be affected or denied.
6. Once the QE has all the information entered into MPEP, eligibility will be determined by Iowa HHS. If the eligibility is not what was expected, it is important to go back through the application to ensure all information was entered correctly.
7. To fully submit the application, the QE must accept the PE results.

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Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

8. After accepting the results, the option to print the Notice of Action (NOA) and application summary are available. Print both, provide a copy to the family including the rights and responsibilities and place a copy in the family's file. This is the only opportunity the QE will have to print the NOA and summary. The family uses the printed NOA as proof of coverage, and can be shown as proof of medical, dental, and pharmacy insurance coverage. PE records must be kept for 7 years for audit purposes.
9. If the application was entered directly into MPEP, the applicant must sign the printed signature page that goes into their file.
10. Document PE, care coordination, and enabling services provided to the client as part of the PE application process, into the Maternal and Child Adolescent Health (MCAH) Data System. Care coordination shall take place with all PEs to provide families with information on the support services available through EPSDT, resources in their community, and available health care services.
11. If there are problems or questions about PE, contact the IME MPEP Support desk IMEMPEPSupport@hhs.iowa.gov or call the DHS help desk at 1-855-889-7985. Note that the phone number for the help desk is the same number used for all programs, so there may be a delay when using this line.

Billing
Contractors receiving Medicaid Administrative Funds (MAF) to provide PE services can bill MH CAH MAF for staff time spent doing the PE for clients.

Resources
Presumptive Eligibility Iowa HHS
General Information – Presumptive Eligibility Frequently Asked Questions
Application for Health Coverage and Help Paying Costs
Addendum to Application for Presumptive Eligibility
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 704-CAH
Title: Presumptive Eligibility for Medicaid and Hawki (Healthy and Well Kids in Iowa)
Effective Date: 10/01/2016
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Overview

Presumptive Eligibility (PE) provides full Medicaid coverage for a limited time, while the Iowa Department of Health and Human Services makes a formal Medicaid eligibility determination. The goal of the PE process is to offer immediate health care coverage to individuals "presumed" to be eligible for Medicaid or Hawki before there has been a full Medicaid determination. The presumptive period lasts until a formal determination is made (enrollment or denial), the application is withdrawn, or until the last of the month following the date of application.

Policy

Contractors shall assist clients in accessing Presumptive Eligibility (PE) through enabling services and public health services and systems. To be eligible for PE, the child and adolescent must be between the ages of 0 and 19, be an Iowa resident, be a U.S. citizen or lawful permanent alien, and meet income requirements. Contractors are required to have a Qualified Entity (QE) within their agency to process applications, and only one PE application can be completed in any 12-month period.

Policy for Medicaid and Hawki Eligibility for Children:

The Medicaid presumptive eligibility process ensures children and adolescents can get immediate healthcare coverage of either Medicaid or Hawki once a final determination is made. Contractors receiving Medicaid Administrative Funds (MAF) to provide PE services can bill CAH MAF for staff time spent doing the PE for clients.

Procedure

The following procedure will be used for conducting a PE:

1. The Hawki Outreach Coordinator will complete the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form and participate in web-based training through the Iowa Department of Health and Human Services. Only a trained QE is allowed to do PE determinations for CAH clients.
2. The QE will use the Medicaid Presumptive Eligibility Portal (MPEP) for presumptive Medicaid or Hawki eligibility determinations. See Policy 706 Hawki Outreach Coordinator.
3. The QE will ask the families for the required information from the Medicaid Presumptive Eligibility Portal Application. Paper applications may be completed. The paper application is the "Application for Health Coverage and Help Paying

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Costs" Application for Health Coverage and Help Paying Costs (form 470-5170) and the Addendum to Application for Presumptive Eligibility (form 47-5192) Addendum to Application for Presumptive Eligibility.

4. The QE will submit all information into MPEP. It is important to obtain all necessary information through MPEP and try not to leave any blanks if possible. A social security number is required for the child but not the parent. If a parent is undocumented or does not have a SSN, the application will not be affected or denied.
5. Once a Contractor has all the information entered into MPEP, eligibility will be determined. If the eligibility is not what was expected, it is important to go back through the application to ensure all information was entered correctly prior to accepting the PE results.
6. To fully submit the application, the Contractor must accept the PE results.
7. After accepting the results, the option to print the Notice of Action (NOA) and application summary are available. Print both, provide a copy to the family, and place a copy in the family's file. This is the only opportunity the QE will have to print the NOA and summary. The family uses the printed NOA as proof of coverage and can be shown to a medical provider in place of a Medicaid card. PE records must be kept for seven years for audit purposes.
8. If the application was entered directly into MPEP, the applicant must sign the printed signature page that goes into their file.
9. Document PE, care coordination, and enabling services provided to the client as part of the PE application process into the MCAH Data System. Care coordination shall take place with all PEs to provide families with information on the support services available through EPSDT, resources in their community, and available health care services.
10. If there are problems or questions about PE, please contact the IME MPEP Support desk imempepsupport@hhs.iowa.gov or call the Iowa HHS help desk at 1-855-889-7985. Please note that the phone number for the Iowa HHS help desk is the same number used for all programs, so there may be a delay when using this line.

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Title: Presumptive Eligibility for Medicaid and Hawki (Healthy and Well Kids in Iowa)
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Authority: Social Security Act Section 1902 [42 U.S. C. 1396a]

Resources

HHS Presumptive Eligibility
General Information – Presumptive Eligibility Frequently Asked Questions
Application for Health Coverage and Help Paying Costs
Addendum to Application for Presumptive Eligibility
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 705
Title: CAH Hawki Outreach
Effective Date: 10/01/2016
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

Overview

The Healthy and Well Kids in Iowa (Hawki) is Iowa's part of the federal Children's Health Insurance Program (CHIP). This federal/state partnership provides critical medical and dental health care coverage to clients/families who do not qualify for traditional Medicaid but cannot afford private coverage. Hawki outreach builds and strengthens local infrastructure through local partnership development, engagement, and promotion/distribution of Hawki materials particularly focused in serving the highest need areas. Outreach is focused on locating working families without health insurance for their children. The Iowa Department of Health and Human Services provides funds to contractors to provide oversight for statewide Hawki community-based outreach and the employment of a Hawki Outreach Coordinator in each CSA. See policy 706 Hawki Outreach Coordinator.

Policy

Contractors shall provide community-based outreach throughout their entire CSA as outlined in the current RFP, RFA, CAH contract, and approved work plan on file with the Department. Contractors shall maintain at least two staff persons who are a Qualified Entity to provide PE throughout the CSA (See Policy 706 Hawki Outreach Coordinator).

Procedure

1. The Hawki Outreach Coordinator will review the client/family needs of all clients indicating they do not have insurance or adequate insurance coverage, assess eligibility for Medicaid/Hawki, and provide PE and care coordination.
2. Contractors shall promote and distribute Hawki brochures (English and Spanish) and eligibility requirements for Hawki (including income guidelines) in the community, on their websites, and on social media platforms.
3. Contractors shall include the following entities in their community-based outreach:
    A. **Schools** - outreach may include visits with school staff but shall focus on times/events when potentially eligible families are present in school settings (i.e., parent-teacher conferences, back-to-school events, community and adult education, summer lunch distribution, etc.).

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Title: CAH Hawki Outreach
Effective Date: 10/01/2016
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B. **Other** - outreach with CSA-specific community sectors/groups and entities such as, but not limited to: faith-based organizations, social service groups/programs, and other programs engaging with the child/adolescent population and families.

C. **Populations with limited access to healthcare services** - outreach may include working with non-profit organizations, employers, and community leaders whose work focuses on populations with less access to healthcare resources (i.e., EMBARC, Iowa International Center, etc.).

D. **Employees without access to employer-sponsored health insurance** - outreach may include visits with independent contractors (gig workers), self-employed persons, and employees that are part-time or lack access to employer-sponsored health insurance (e.g., restaurant/grocery stores/food service industry, retail, early care and education (ECE) providers, entrepreneur incubators, artist cooperatives, farm cooperatives, etc.).

Resources

Healthy and Well Kids in Iowa (Hawki)
InsureKidsNow.gov
Social Security Act Section 1902 [42 U.S. C. 1396a]

Number: 706
Title: CAH Hawki Outreach Coordinator
Effective Date: 10/01/2016
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

Overview

The Healthy and Well Kids in Iowa (Hawki) program is Iowa's part of the federal Children's Health Insurance Program (CHIP). This federal/state partnership provides critical medical and dental health care coverage to clients/families who don't qualify for traditional Medicaid but can't afford private coverage. The Iowa Department of Health and Human Services provides funds to MCAH Contractors to provide oversight for statewide Hawki community-based grassroots outreach and employment of a Hawki Outreach Coordinator (HOC) in each CSA (see Policy 705 Hawki Outreach). The HOC builds and strengthens local infrastructure through local partnership development, engagement, and promotion/distribution of Hawki materials to serve populations who are underserved and uninsured, increases local public health system capacity, and ensures critical enabling and population services are performed in the CSA.

Policy

CAH Contractors will employ or contract a Hawki Outreach Coordinator (HOC) to serve their CSA. The HOC will provide community-based grassroots outreach to each of the required populations (see Policy 705 Hawki Outreach). The HOC and contingency HOC will be certified Qualified Entities (QE) through Iowa HHS.

Procedure

Becoming a Qualified Entity: The Hawki Outreach Coordinator (HOC) and contingency HOC are required to be a certified Qualified Entity (QE). They will complete the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request and participate in web-based training through the Iowa Department of Health and Human Services. Only a trained and approved QE is allowed to do PE determinations for CAH clients.

1. In the application to become a QE, Contractors are required to check the box to receive future emails from IME. IME will send out newsletters and up-to-date information. The contractor can choose the "children" or "hospitals" box and then select your *provider type* (Screening Center for CAH).
2. To be certified as a QE, Contractor staff and/or subcontractors will:
    a. Review the Provider Education PE and MPEP Training
    b. Review the Memorandum of Understanding with a Provider for PE Determinations.

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Title: CAH Hawki Outreach Coordinator
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c. Request access to MPEP by completing the Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form. The Access Request Form will set the certified QE up to obtain usernames and passwords for MPEP.

PE for Clients: A certified QE shall assist clients who may meet eligibility requirements either for Hawki or Medicaid in applying for PE through the Medicaid Presumptive Eligibility Portal (MPEP) portal that is used by an approved qualified entity (QE) for presumptive eligibility (see Policy 704 Presumptive Eligibility for Medicaid and Hawki). Only one PE may be completed in any 12-month period. Contractors are highly encouraged to ask about "all" and other family members who may need assistance with health care coverage. Assuring health care coverage for all the family is the ultimate goal.

Procedure for Outreach:

1. The HOC will focus outreach and PE to specific required populations, which include schools, populations with less access to healthcare services, employees without access to employer-sponsored health insurance, and other populations (see Policy 705 Hawki Outreach).
2. The HOC will:
   a. Use best practice outreach strategies to encourage enrollment in Hawki and Medicaid programs. This could include meeting parents of young children where they congregate (i.e., school, church, library, YMCA, etc.), connecting with adults of the populations through work, social events, church, community-sponsored events, etc., and connection with other community organizations serving these populations.
   b. Ensure dissemination of approved and up-to-date program information. This could include through the Contractor's website and social media accounts, visiting small employers, schools, grocery stores, etc.
   c. Complete required reports and attend required Hawki meetings.
   d. Conduct Hawki Outreach to businesses and organizations in the community providing onsite PE throughout the CSA.

Number: 706
Title: CAH Hawki Outreach Coordinator
Effective Date: 10/01/2016
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Title XXI of the Social Security Act 1902 [42 U.S. C. 1396a]

e. Conduct Hawki Outreach outside traditional business hours (8 am to 4:30 pm Monday through Friday) and on weekends to provide education and assistance with PE to individuals with a variety of work schedules.
f. Build partnerships within HHS programs including: WIC, 1st Five, I-Smile™ and CCNC.

Resources

Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request
Provider Education PE and MPEP Training
Social Security Act Section 1902 [42 U.S. C. 1396a]

IOWA | Health and Human Services

Number: 707-MH
Title: MH Eligibility and Applying for Medicaid
Effective Date: 10/01/2022
Revision Date: 09/05/2025
Date of Last Review: 09/05/2025
Authority: Iowa Administrative Code 641 IAC 76.7

Overview

Contractors are required to assist pregnant and postpartum women in accessing quality and affordable healthcare coverage through Medicaid. Pregnant women may be eligible for full Medicaid coverage due to their income alone, full Medicaid due to their pregnancy, or Presumptive Eligibility Only. Pregnant women who only qualify for Medicaid while pregnant due to having a higher income are automatically enrolled in the State Family Planning Program (FPP).

The Title V agencies (CSA's) partner with the Department of Human Services and clients in applying for health care coverage through the Iowa Medicaid Managed Care Organizations, and dental coverage through Pre-Ambulatory Health Plans.

Policy

Trained agency staff who have completed the web-based training module and been certified by DHS can assist families in applying for Medicaid by gathering the necessary information for the application in the MPEP (Medicaid Presumptive Eligibility Portal). Once an eligibility determination for Medicaid is completed by MPEP, the client will be provided a Notice of Award (NOA). The client will have benefit information sent to their residence, including medical cards. Eligibility determination must be completed at least once annually. If the individual and/or family's circumstances change in a manner that affects third-party coverage or Title XIX eligibility, eligibility determination shall be completed at that time.

Procedure

Applying for Medicaid: There are two ways Contractors can assist clients in applying for Medicaid. Contractors should discuss with the family and select the application process that best fits the needs of the family. The options include:

1. Self-Service Portal (online): Contractors use the Self Service Portal Home Page to directly input client data to see if clients are eligible for health care coverage from the Medicaid/Hawki Review form 470-5168
2. Paper Application: The Contractor can also download the paper Application for Health Coverage and Help Paying Costs and Addendum to Application for Presumptive Eligibility for the client to complete. Once completed, the client can mail directly into DHS or bring back to the Contractor to be mailed to DHS. It is recommended that Contractors use the Self-Service Portal vs paper application for efficiency and to expedite DHS response to the application.

IOWA | Health and Human Services

Number: 707-MH
Title: MH Eligibility and Applying for Medicaid
Effective Date: 10/01/2022
Revision Date: 09/05/2025
Date of Last Review: 09/05/2025
Authority: Iowa Administrative Code 641 IAC 76.7

Assessing Income: Income is assessed on pregnant women based on Federal Poverty Guidelines (published annually by the U.S. Department of Health and Human Services (DHHS)), family income, and household size (which includes the unborn child). It is ***not*** the role of the Hawki Outreach Coordinator or other staff to verify income for a household; the individual or family self-declares income information.

Eligibility Criteria for Full Medicaid Coverage*:

1. pregnant women of any age
2. resident of Iowa and a citizen of the U.S or qualified alien*; and
3. household gross income is 215% of the Federal Poverty Level.

*applicants who do not meet the citizenship/alien status may apply for Presumptive Eligibility only. Refer to policy 704MH: Presumptive Eligibility for Pregnant Women.

Eligibility Criteria for the State Family Planning Program*:

1. Men and women ages 12-54;
2. resident of Iowa and a citizen of the U.S or qualified alien;
3. not a dependent of a State of Iowa employee;
4. household gross income up to 300% of the Federal Poverty Level**.

*The FPP only covers limited family planning-related services and does not qualify as minimum essential coverage under the Affordable Care Act

**Women whose pregnancies and deliveries were covered by Medicaid will have FPP services for 12 months postpartum without having their eligibility redetermined.

Resources

Application for Help Covering Costs
Addendum to Application for Presumptive Eligibility
State Family Planning Program
Medicaid Programs
HHS Services Portal
Department of Human Services Contact Center toll-free number 1-855-889-7985
Iowa Administrative Code 641 IAC 76.7 (135)

Number: 707-CAH
Title: Applying for Health Coverage—Hawki and Medicaid
Effective Date: 10/01/2016
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Iowa Administrative Code 641 IAC 76.7 (135)

Overview

The purpose of applying for Medicaid and Hawki health care coverage is to get access for uninsured children and adolescents in Iowa to receive quality, affordable health care coverage either through Medicaid (eligible birth to 21) or Hawki (eligible birth up to age 19). When applying for either Hawki or Medicaid health care coverage, Contractors are assisting clients in obtaining health care coverage through managed care organizations (MCOs) who are contracted with the Iowa Department of Health and Human Services to provide benefits to clients. Free or low-cost oral health coverage is available through Medicaid and Hawki or clients can apply for Hawki Dental Only if they have existing medical insurance and meet income requirements.

Policy

The Hawki Outreach Coordinator (HOC) or trained agency staff (that have completed a web-based training module and are certified by Iowa HSS) can assist families in applying for Medicaid or Hawki by gathering the necessary information for the application in the MPEP (Medicaid Presumptive Eligibility Portal). Once a presumptive eligibility determination is completed in the IME MPEP system, the client will be provided a Notice of Action (NOA) declaring approval or denial for presumptive eligibility benefits. The client can choose for the presumptive eligibility application to be sent to IME for continuing eligibility determination of ongoing Medicaid or Hawki benefits. Medicaid or Hawki eligibility determination must be completed at least once annually. If the individual and/or family's circumstances change in a manner that affects third-party coverage or Title XIX or Title XXI eligibility, eligibility determination shall be completed at that time.

Procedure

Applying directly for Medicaid or Hawki: There are three ways Contractors can assist clients in applying for Medicaid or Hawki. Contractors should discuss with the family and select the application process that best fits the needs of the family. The options include:

1. Self-Service Portal (online): Contractors use the Self Service Portal Home Page to directly input client data to see if clients are eligible for health care coverage.
2. Paper Application: The Contractor can also download the paper Application for Health Coverage and Help Paying Costs and Addendum to Application for Presumptive Eligibility for the client to complete. Once completed, the client can mail it directly to HHS or bring it back to the Contractor to be mailed to Iowa HHS.

Number: 707-CAH
Title: Applying for Health Coverage—Hawki and Medicaid
Effective Date: 10/01/2016
Revision Date: 09/04/2025
Date of Last Review: 09/04/2025
Authority: Iowa Administrative Code 641 IAC 76.7 (135)

It is recommended that Contractors use the Self-Service Portal vs paper application for efficiency and to expedite HHS response to the application.

3. Presumptive Eligibility application through the MPEP system.

Assessing Income: Income is assessed on all children and adolescents based on Federal Poverty Guidelines (published annually by the U.S. Department of Health and Human Services (DHHS)), family income, and household size. It is ***not*** the role of the Hawki Outreach Coordinator or other staff to verify income for a household; the individual or family self-declares income information.

Eligibility Criteria for Medicaid:

1. Children and adolescents ages birth to 21 years; adults 19-64 years of age
2. Resident of Iowa and a citizen of the U.S or qualified alien; and
3. Household gross income up to 167% of the Federal Poverty Level.

Eligibility Criteria for Hawki: Some households may be required to pay a monthly premium based on family income. No family pays more than $40 a month, and some pay nothing.

1. Children and adolescents aged birth to 19 years;
2. Resident of Iowa and a citizen of the U.S or qualified alien;
3. Not a dependent of a State of Iowa employee;
4. Have no other health insurance (including Medicaid); and
5. Household gross income up to 302% of the Federal Poverty Level.

Resources

Application for Health Coverage and Help Paying Costs
Addendum to Application for Presumptive Eligibility
Healthy and Well Kids in Iowa (Hawki)
Medicaid Programs
Iowa HHS Self Service Portal
Iowa Administrative Code 641 IAC 76.7 (135)

IOWA Health and Human Services

Number: 708
Title: Medical and Dental Transportation
Billing Codes: Non-emergency bus A0110; Non-emergency taxi A0100; Non-emergency wheelchair van A0130; Non-emergency by volunteer A0090; Non-emergency mini-bus/transportation system A0120; Parking fees, tolls A0170
Effective Date: 10/01/2022
Revision Date: 09/05/2025
Date of Last Review: 09/05/2025
Authority: Screening Centers Provider Manual

Overview

Medicaid non-emergency medical transportation (NEMT) is an important benefit for clients who need to get to and from medical/dental services but have no means of transportation, this can include:

1. Not having a valid driver's license;
2. Not having a working vehicle available in the household;
3. Being unable to travel or wait for services alone or
4. Having a physical, cognitive, mental, or developmental limitation.

Policy

To help ensure that Medicaid members have access to medical and dental care within the scope of the program, Contractors will arrange NEMT for Medicaid-eligible non-MCO enrolled clients and Title V eligible clients.

Procedure

NEMT for Medicaid-eligible non-MCO enrolled clients and Title V eligible Clients

1. Contractors are eligible for reimbursement of non-emergency medical and dental local transportation when they arrange or provide transportation using the service codes listed for eligible clients.
2. The transportation must be to a Medicaid-enrolled provider for a Medicaid-covered service on the day of the Medicaid-covered service to be eligible for reimbursement.
3. Transportation must be in compliance with state laws (i.e., using child car seats) and must be the most appropriate for the circumstances of the family.
4. Contractors must maintain documentation of transportation service.

Documentation

Complete in the MCAH data system:

1. First and last name of service provider & credentials.
2. Date of service.
3. Member's name.
4. Address of where member was picked up.
5. Destination (medical provider's name and address).
6. Mileage if the transportation is paid per mile.
7. The invoice for the cost of the transportation service must be accessible. This may be reported in the 'Comments' field or maintained on a transportation log.

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Effective Date: 10/01/2022
Revision Date: 09/05/2025
Date of Last Review: 09/05/2025
Authority: Screening Centers Provider Manual

8. If the Title V agency keeps a service log containing key information, the 'Comments' in the MCAH data system must include a reference to this record.

Billing:

1. The following are billable codes for billing IME for Medicaid fee-for-service (non-MCO) clients. This includes clients on presumptive eligibility. In the diagnosis area of the claim form, use diagnosis code Z76.89:
    a. Code A0110: Non-emergency bus (per round trip)
    b. Code A0100: Non-emergency taxi (per round trip)
    c. Code A0130: Non-emergency wheelchair van (per round trip)
    d. Code A0090: Non-emergency by volunteer (per mile)
    e. Code A0120: Non-emergency mini-bus or non-profit transportation system (per round trip)
    f. Code A0170: Parking fees, tolls
2. Local transportation billed should align with the agency's transportation plan.
3. Bill actual cost of transportation for the date the transportation was provided to the health-related appointment.
4. There is no payment for the transportation service if the client does not show up for the ride.

NEMT for Medicaid eligible MCO enrolled clients

NEMT for Medicaid-eligible MCO-enrolled clients is facilitated through a transportation broker contracted by Iowa HHS or the MCO for transportation services for clients.

1. MTM is the transportation broker for Medicaid fee-for-service (non-MCO) clients. They arrange and pay for transportation (both in-town and out-of-town) to Medicaid-covered services. For information about their policies and processes, visit their website or call them at 866-572-7662.
2. Each Medicaid MCO has their own transportation broker for serving MCO-enrolled clients:
    a. Wellpoint: Access2Care at 844-544-1389
    b. Iowa Total Care: Access2Care at 877-271-4819
    c. Molina: Access2Care at 866-849-2062
3. When a member needs transportation or reimbursement for transportation, the member must contact the broker 72 business hours in advance for approval and scheduling.

IOWA | Health and Human Services

Number: 708
Title: Medical and Dental Transportation
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Effective Date: 10/01/2022
Revision Date: 09/05/2025
Date of Last Review: 09/05/2025
Authority: Screening Centers Provider Manual

Resources

Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule

Sources

CMS: Non-Emergency Medical Transportation (NEMT)

IOWA Health and Human Services

Number: 709
Title: Interpretation Services
Billing Codes: Sign language or oral interpretive services - T1013 or D9990; Telephonic oral interpretative services - T1013UC
Effective Date: 10/01/2016
Revision Date: 09/05/2025
Date of Last Review: 09/05/2025
Authority: Section 1557 of the Patient Protection and Affordable Care Act; 45 CFR § 92.101

Overview

More than 25 million Americans speak English "less than very well," according to the U.S. Census Bureau (2014). This population is less able to access health care and is at higher risk of adverse outcomes such as drug complications and decreased patient satisfaction. Title VI of the Civil Rights Act mandates that interpreter services be provided for patients with Limited English Proficiency (LEP) who need this service despite the lack of reimbursement. Changes in 2016 to Section 1557 of the Affordable Care Act (ACA) significantly changed the requirements for medical interpretation. Contractors must assure they are in compliance with Section 1557 and the most current version of the regulations implementing this Act.

Policy

Contractors will ensure that persons with LEP have meaningful access and an equal opportunity to participate in services, activities, programs, and other benefits. Contractors shall also provide for communication of information contained in vital documents, including but not limited to waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc.
All interpreters, translators, and other aids required by federal law shall be provided without cost to the person being served, and clients and their families will be informed of the availability of such assistance free of charge. Qualified interpreters (see below for definition) must be used for medical interpretation and may include staff interpreters, contracted interpreters, formal arrangements with local organizations providing interpretation or translation services, or video/telephone interpretation services. Minor children and adult family members are prohibited from serving as medical interpreters. The two exceptions to this rule allow (1) for minor children to interpret or facilitate conversation only in an emergency involving an imminent threat to safety or welfare and if a qualified interpreter is not available or (2) for an adult accompanying an individual with LEP to interpret or facilitate conversation only in an emergency involving an imminent threat to safety or welfare and if a qualified interpreter is not available; or if the individual with LEP specifically requests that the adult interpret or facilitate conversation, the adult agrees, and reliance on the adult is appropriate under the circumstances. (Source: Section 1557 of ACA).

Procedure

Identifying persons with LEP and their language: Contractors will promptly identify the language and communication needs of all clients. If necessary, staff will use a language identification card (or "I speak cards," available on the Department of Justice Limited English Proficiency website) or posters to determine the language. In addition, when records of past interactions with clients or family

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members are kept, the language used to communicate with the client will be included as part of the record.

Obtaining a qualified interpreter: Contractors are responsible for maintaining an accurate and current list showing the name, language, phone number, and hours of availability of contracted interpreters or qualified staff interpreters (not just bilingual staff who have other duties). A "qualified interpreter" is defined as an interpreter who "via a remote interpreting service or an on-site appearance":

1. adheres to generally accepted interpreter ethics principles, including client confidentiality;
2. has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
3. is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology.

Qualified bilingual/multilingual staff: Qualified bilingual/multilingual staff is defined as "a member of a provider's workforce who is designated to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has **demonstrated**" [emphasis supplied] that he or she is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology, and is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

Sign language interpreters should be licensed pursuant to Iowa Administrative Code Chapter 154E.

Minors as interpreters: Minor children are banned from serving as medical interpreters. The only exception to this rule is "an emergency involving an imminent threat to the safety or welfare of an individual or the public where no qualified interpreter is immediately available." However, since most leading national telephone and video remote interpreting companies can make qualified interpreters available in hundreds of languages within seconds, this exception should be regarded as limited.

Family/Friends as interpreters: Adult family members and friends are prohibited from acting as medical interpreters. However, there are two allowable exceptions to this general rule. First, adult family members and friends may be used as medical interpreters in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified

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interpreter is immediately available. Second, adult family members and friends may be used as medical interpreters where the LEP person "specifically requests that the accompanying adult interpret or facilitate communication and the accompanying adult agrees to provide such assistance." However, the rule makes plain that providers are not relieved of their legal duty to provide a qualified medical interpreter where an LEP patient elects to use an adult family member or friend since even then, "reliance on that adult [family member or friend must be] appropriate under the circumstances."

Providing written translations: Contractors will provide translation of written materials, if needed, as well as written notice of the availability of translation, free of charge, for clients. Written translators must:

1. Adhere to generally accepted translator ethics principles, including client confidentiality;
2. Have demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and
3. Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Public/patient notice requirement: Contractors will inform clients of the availability of language assistance, free of charge, by providing written notice in language clients will understand. Contractors must provide a notice encompassing seven factors, including that the entity treats all individuals fairly and ensures the provision of necessary interpreter services and communication assistance, and that it provides appropriate interpreters and auxiliary aids and services, free of charge, to provide necessary language services to individuals requiring assistance. These notices must include taglines in the top 15 languages spoken nationally. These notices must be included in "significant publications" and posted in "conspicuous physical locations where the entity interacts with the public." In particular, such notices must be accessible from the organization's website.

Medicaid requirements: In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

1. Provided by interpreters who provide only interpretive services.
2. Interpreters may be employed or contracted by the billing provider.
3. The interpretive services must facilitate access to Medicaid-covered services.

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid-covered service. Medical staff who are bilingual are reimbursed only for their medical services, not for the interpretation services they provide.

IOWA | Health and Human Services

Number: 709
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Authority: Section 1557 of the Patient Protection and Affordable Care Act; 45 CFR § 92.101

Documentation of the service: The billing provider must document in the client's record the:

1. Interpreter's name or company,
2. Date and time of the interpretation,
3. Service duration (time in and time out), and
4. Cost of providing the service.

Billing interpreter services: Follow these guidelines for billing interpreter services:

1. For medical services bill code T1013 – documenting verbal or sign language interpretation.
    a. For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
    b. The lack of the UC modifier will indicate that the charge is being made for the 15-minute face-to-face unit.
    c. Enter the number of minutes actually used for the provision of the service. The 15-minute unit should be rounded up if the service is provided for 8 minutes or more. Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **not** used, and the units exceed 24 will be paid at 24 units.
2. For dental services bill code D9990 - documenting verbal or sign language interpretation services.
    a. Interpretation is only billable when provided in conjunction with a direct dental service. In addition, the service must be face-to-face (not telephonic) and is billable one time per day per member (no longer billed in 15-minute increments).
    b. For information on access to telephonic translation services, please refer to the contact information for each dental plan administrator:
        i. IME Provider Services Unit: 1-800-338-7909
        ii. Delta Dental of Iowa (DDIA) Provider Services: 1-800-472-1205
        iii. Managed Care of North America (MCNA) Provider Services 1-855-856-6262.
3. Billable interpretation services are provided by interpreters who provide **only** interpretation services. Agency staff with other roles cannot have split FTEs that include billable interpretation.
4. Interpreters are either employed or contracted by the Contractor billing the services.
5. Service providers who are also bilingual are not reimbursed for interpretation, only for their medical/dental services.
6. Interpretation services must facilitate access to Medicaid covered services. Providers may bill Medicaid only if the services are offered in conjunction with another Medicaid covered service.

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7. Contractors may bill Iowa HHS for interpretation services during care coordination, Informing, and Presumptive Eligibility using MH and CAH MAF funds.
8. Medicaid does not reimburse for written translation of printed documents. Written translation of printed documents used during care coordination, informing, and presumptive eligibility may be billed to Iowa HHS using MAF funds.

Documentation

1. Document in the MCAH data system
2. Document in medical record. Include the service for which the interpretation was provided, the name of the interpreter or company, the duration of service, and the cost of service.
3. If the Title V agency keeps a service log containing the above information, the 'Comments' section in the MCAH data system and medical record must include a reference to this record.

Resources

Section 1557 of the Affordable Care Act (ACA)
45 CFR § 92.101
Title VI of the Civil Rights Act
Iowa Administrative Code Chapter 154E
Iowa HHS Medicaid Screening Center Provider Manual
Iowa EPSDT Periodicity Schedule
Limited English Proficiency (LEP) Resources for Effective Communication
Nondiscrimination and the ACA, Health Advocate, a publication of the National Health Law Program, September 2015 by Mara Youdelman, J.D.
DHHS press release announcing the release of the final ACA section 1557 rules.

Sources

National Council on Interpreting in Health Care
American Family Physicians Journal: Appropriate Use of Medical Interpreters
Section 1557 of the Affordable Care Act (ACA)
45 CFR § 92.101
New 2016 ACA Rules Significantly Affect the Law of Language Access, CME Learning, D. Hunt, J.D., May 14, 2016.

IOWA | Health and Human Services

Number: 710
Title: CAH Well Child Exam Reminders
Effective Date: 10/01/2022
Revision Date: 09/08/2025
Date of Last Review: 09/08/2025
Authority: Iowa HHS Omnibus Agreement

Overview

Providing well-child exam reminders based on the EPSDT Care for Kids Periodicity Schedule is the responsibility of CAH program Contractors. A report that includes these populations comes from the MCAH data system at the first of the month. This identifies clients to be reminded of upcoming well-child exams.

Policy

Contractors shall remind eligible clients about upcoming or overdue well-child exams.

Procedure

1. Clients eligible for well-child exam reminders live in your CSA and are enrolled in Fee-For-Service Medicaid or live in your CSA and were enrolled in the CAH program in the last two (2) years per the MCAH data system.
2. A report that includes these populations comes from the MCAH data system and is available to the Contractor around the first of the month. This identifies clients to be reminded of upcoming well-child exams.
3. If the well child exam reminder is conducted by phone conversation with the client, texting to and from the client, or face-to-face, this may be categorized as care coordination if care coordination is provided (see Policy 703 Care Coordination).
4. If the well-child exam reminder is conducted by mailing a letter or postcard, sending a text message that is not responded to by the client, leaving a voicemail message, or by phone, text, or in person, but care coordination is not provided, this is entered into the MCAH data system as ‘Send/Give Educational Materials’.

Documentation: See the MCAH data system User Manual for guidance on documenting this service

Billing

1. Contractors may use Medicaid Administrative Funds (MAF) to cover expenses related to the well-visit exam reminder for clients enrolled in Medicaid.
2. Contractors may use Title V funds to cover expenses related to the well-visit reminder for clients enrolled in Title V (see Policy 106 Child & Adolescent Health Program Eligibility & Voluntary Participation for Title V eligibility).

Resources

Iowa HHS Omnibus Agreement