



Alternative Benefit Plan

State Name: Iowa

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: IA - 26 - 0009

Benefits Description

ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package.

No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Wellmark Blue Access State Employee Plan

The "Benefit Provided" field lists the name of each benefit the same way it was described in the Section 1115 Waiver. If the name (but same benefit) was different in the Base Benchmark State Employees Plan documents, this benefit name is stated in the "other description" field in all of ABP5, if applicable for that particular benefits.

Dental services will be provided through contract(s) with PAHP(s).

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved



Alternative Benefit Plan

☒ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Primary Care Illness/Injury Physician Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Athletic Trainers are not covered.

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

Physicians and Practitioners

Benefit Provided:

Specialty Physician Services

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Physicians and Practitioners.

NOTE: Iowa's Benchmark does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.

Benefit Provided:

Home Health Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

Not Covered: Custodial home care services and supplies, which help with daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking or getting in and out of bed; aid in bathing, dressing feeding and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. In order for care to be approved, must be approved by physician.

Benefit Provided:

Chiropractors

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Surgery- Outpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Second Surgical Opinion

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Allergy Testing and Injections

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Allergy Testing and Treatment

Benefit Provided:

Chemotherapy- Outpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

IV Infusion Services

Source:

Base Benchmark State Employees

Remove



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Prescription Drugs

Benefit Provided:

Radiation Therapy- Outpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Dialysis- Outpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered as an inpatient in a hospital or in a Medicare approved dialysis center (outpatient).

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



Alternative Benefit Plan

Benefit Provided:

Anesthesia

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Ambulatory anesthesia is used for surgical procedures where the patient does not need to stay overnight in the hospital. The same anesthetics that are used in the operating room setting are used in the ambulatory setting, including general, regional and local anesthetics. Sedation anesthetics are also given in the ambulatory setting.

Benefit Provided:

Urgent Care/Walkin Centers

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Used for sudden illness or injury and who need to see a doctor right away. Clinics are often called minor emergency, urgent care, or immediate care centers.

Benefit Provided:

Access to Clinical Trials

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

The state assures:

1. Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.
2. A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).
3. A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3). General Condition of Coverage

Benefit Provided:

Genetic Testing

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Genetic testing for purely informational purposes is not covered.

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

Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following are met: Appropriate candidate for a test under medically recognized standards, and outcome of the test is expected to determine a covered course of treatment or prevention.

NOTE: Iowa's Benchmark does not mention prior authorization for this service but Iowa will be following Iowa Medicaid prior authorization guidelines where only some services will require prior authorization.

Benefit Provided:

Dental Treatment for Accidental Injury

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Care must be completed within 6 months of.....

Scope Limit:

See Other Information below for Covered and Not Covered services.

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

Duration limit continued: injury. Treatment must have occurred while the member was covered under this group health plan.

Covered Services:

Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if: Based on a determination by a licensed dentist and treating physician, one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental



Alternative Benefit Plan

treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
Impacted teeth removal (surgical) as an inpatient or outpatient of a facility only when a medical condition exists (such as hemophilia) that requires hospitalization.
Facial bone fracture reduction.
Incisions of accessory sinus, mouth, salivary glands, or ducts.
Jaw dislocation manipulation.
Orthodontic services required for surgical management of cleft palate.
Treatment of abnormal changes in the month due to injury or disease.

Not Covered:

General dentistry including, but not limited to, diagnostic and preventative services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or surgical management of cleft palate.
Injuries associated with or resulting from the act of chewing.
Maxillary or mandibular tooth implants (osseo integration).

Benefit Provided:

Hospice Care- Outpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Terminally ill patient and have a life expectancy of six months or less.

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

Terminally ill patients have a life expectancy of six months or less. Services to provide comfort and support for persons in the last stages of terminal illness and their families. In accordance with Section 2302 of the Affordable Care Act, individuals under age 21 (age 19 and 20 for purposes of this benchmark plan), must receive hospice care concurrently with curative care.

Benefit Provided:

Inhalation Therapy

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

60 visits per benefit year

Scope Limit:

None

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

Respiratory or breathing treatments to help restore or improve breathing function.



Alternative Benefit Plan

Benefit Provided:

Medical and Surgical Supplies

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Medical supplies and devices such as dressing and casts, oxygen and equipment needed to administer oxygen.

Add



Alternative Benefit Plan

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided:

Emergency Room Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Emergency Services

Benefit Provided:

Emergency Transportation- Ambulance & Air

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

No other method of transportation is appropriate.

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

Scope limit continued: Services required to treat patient illness or injury are not available in the facility where the patient is currently receiving care if patient is an inpatient at a facility. Patient is transported to the nearest hospital or nursing facility in network with adequate facilities to treat condition. In emergency situation, patient may seek care at the nearest appropriate facility whether the facility is in or out of network.

Add



Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided:

General Inpatient Hospital Care

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Hospitals and Facilities

Benefit Provided:

Inpatient Physician Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Inpatient Surgical Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

Hospitals and Facilities

Benefit Provided:

Non-cosmetic Reconstructive Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Cosmetic services, supplies, or drugs are not covered unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any...

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

Scope Limit Continued: complications resulting from noncovered cosmetic procedures.
Hospitals and Facilities

Benefit Provided:

Transplant Organ and Tissue

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel...

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

Scope continued: Not covered- transport of living donor, expenses related to purchase of organ, services/supplies related to mechanical or non-human organs, transplant services and supplies not listed in the Covered Services above. Any complications resulting from the Not Covered benefits listed would not be covered.
Transplants

Benefit Provided:

Congenital abnormalities correction

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Reconstructive Surgery

Benefit Provided:

Anesthesia- Inpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Chemotherapy- Inpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Radiation Therapy- Inpatient

Source:

Base Benchmark State Employees

Remove



Alternative Benefit Plan

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Breast Reconstruction

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Reconstructive Surgery

Benefit Provided:

Hospice Care- Inpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Terminally ill patient and have a life expectancy of six months or less.

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

Inpatient services in a hospice facility. Services to provide comfort and support for persons in the last stages of terminal illness and their families. In accordance with Section 2302 of the Affordable Care Act, individuals under age 21 (age 19 and 20 for purposes of this population), must receive hospice care concurrently with curative care.



Alternative Benefit Plan

Benefit Provided:

Hospice Respite- Inpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Limited to 15 days per lifetime for inpatient...

Scope Limit:

None

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

Duration continued: hospice respite care (can take place in a nursing home or hospital). Hospice respite care must be used in increments of not more than 5 days at a time.

Benefit Provided:

Dialysis- Inpatient

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered as an inpatient in a hospital or in a Medicare approved dialysis center (outpatient)

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

Add



Alternative Benefit Plan

■ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Maternity/Preg-Pre&Post Care-deliv, inpat nutritio

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Maternity care and newborn care not covered if mother is a surrogate mother. Would not cover a person for surrogate only purposes. If individual meets requirements for coverage under the new adult group she would be covered in that group.

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

If length of stay is less than 48 or 96 hours, a follow-up postpartum home visit by an RN is covered.

Benefit Provided:

Midwife Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Physicians and Practitioners

Add



Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including

Collapse All ☐

☒ behavioral health treatment

☒ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Benefit Provided:

Mental Health/Behavioral Health Inpatient Treatmen

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Residential Facility services are not covered.

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

Mental Health Services

Iowa assures that mental health services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Benefit Provided:

Mental Health/Behavioral Health Outpatient Treatme

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Mental Health Services

Iowa assures that mental health services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Benefit Provided:

Substance Abuse Inpatient Treatment

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Residential Facility services are not covered

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

Chemical Dependency Treatment

Iowa assures that mental health services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Benefit Provided:

Substance Abuse Outpatient Treatment

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Chemical Dependency Treatment

Iowa assures that mental health services covered in this alternative benefit plan will not be provided in an institution for mental diseases.

Add



Alternative Benefit Plan

☒ 6. Essential Health Benefit: Prescription drugs

- ☒ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☒ Limit on number of prescriptions
- ☒ Limit on brand drugs
- ☒ Other coverage limits
- ☒ Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

Iowa's ABP prescription drug benefit plan is the same (duplication of plan) as the approved Medicaid state plan for prescribed drugs.

NOTE: Some medications do require prior authorization, for example, to verify that a prescription drug is part of a specific treatment plan and is medically necessary.



Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All ☐

- ☒ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided:	Source:	Remove
Physical Therapy	Base Benchmark State Employees	
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	Each therapy limited to 60 visits per year	
Scope Limit:		
Rehabilitative speech therapy services are covered...		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Scope Limit continued: when related to a specific illness, injury, or impairment and involve the mechanics of phonation, articulation or swallowing. Services must be provided by a licensed or certified speech pathologist. Speech therapy requires prior approval.		
Not Covered: Physical therapy and occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization. Speech therapy not provided by licensed or certified speech therapist.		
PT, OT and ST are considered rehab/hab services. The 60 visit limit is combined between habilitation and rehabilitation; however, the limit may be exceeded based on medical necessity.		

Benefit Provided:	Source:	Remove
Durable Medical Equipment	Base Benchmark State Employees	
Authorization:	Provider Qualifications:	
Prior Authorization	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
Home/Durable Medical Equipment		
NOTE: Iowa's ABP does not mention prior authorizations for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.		



Alternative Benefit Plan

Benefit Provided:

Prosthetic Devices

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Eyeglasses, air conduction hearing aids or examinations or fittings are not covered. Elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription are not covered.

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

Benefit Provided:

Cardiac Rehabilitation

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Pulmonary rehabilitation

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Alternative Benefit Plan

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

Benefit Provided:

Skilled Nursing

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

120 days per benefit year for services in...

Scope Limit:

None

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

Duration limit continued: a hospital or nursing facility.

Add



Alternative Benefit Plan

■ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided:

Laboratory Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

X-ray Services

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Imaging- MRI, CT and PET

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Some procedures require prior approval.



Alternative Benefit Plan

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

X-ray Services

Benefit Provided:

Sleep Studies

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Treatment for snoring not covered without diagnosis of sleep apnea.

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

Sleep Apnea Treatment

Benefit Provided:

Diagnostic Genetic Tests

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Genetic molecular testing and related counseling are covered if appropriate candidate for a test under medically recognized standards (i.e. family background, past diagnosis etc.) and outcome of test is...

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

Scope Limit continued: expected to determine a covered course of treatment or prevention and is not merely informational.

Benefit Provided:

Pathology

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Alternative Benefit Plan

Scope Limit:

None

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

X-ray and Laboratory Services

Add



Alternative Benefit Plan

☒ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:

Hearing Exam- Adult

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

One hearing exam per benefit year.

Scope Limit:

Hearing aids are not covered.

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

Hearing Services

Benefit Provided:

Diabetes-med necessary equip & supplies

Source:

Base Benchmark State Employees

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Insulin and Diabetic Supplies

NOTE: Iowa's Benchmark does not mention prior authorization for this service but Iowa will be following Medicaid prior authorization guidelines where only some services will require prior authorization.

Benefit Provided:

Prostate cancer screening

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

one exam per year



Alternative Benefit Plan

Scope Limit:

Men age 50-64

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

X-ray and Laboratory Services

Benefit Provided:

Foot care

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Must be related to medical condition. Routine foot care is not covered.

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

Add



Alternative Benefit Plan

☒ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

Base Benchmark State Employees

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Age 19 and 20 will receive EPSDT services.

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

Add



Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark

Collapse All ☐



Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted:

Prescription Drugs

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Iowa's ABP prescription drug benefit plan is the same (duplication of plan) as the approved Medicaid state plan for prescribed drugs.

Add



Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	Remove
Adult Vision	Base Benchmark	
Explain why the state/territory chose not to include this benefit:		
Adult vision is covered in the base benchmark plan but is an excepted benefit and therefore not an Essential Health Benefit.		
Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	Remove
Newborn Child Coverage	Base Benchmark	
Explain why the state/territory chose not to include this benefit:		
This service is covered under the base benchmark plan but is not applicable for the new adult group population that is for ages 19-64. The adult member must enroll the newborn child for coverage.		
		Add



Alternative Benefit Plan

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

Collapse All ☐

Other 1937 Benefit Provided:

Non-emergency Medical Transportation Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See "Other" section

Other:

Non-emergency Medical Transportation (NEMT) is available when the member needs transportation to receive services covered by Medicaid, from a Medicaid enrolled provider. Consistent with member needs and subject to limitations and restrictions in IAC 441-78.13 (outlined below) and advance approval of the transportation broker, NEMT coverage may include:

- a. Mileage reimbursement to the member, if the member is the driver.
- b. Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- c. Taxi service.
- d. Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- e. Wheelchair and stretcher vans.
- f. Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.
- g. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.
- h. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.
- i. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.
- j. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

NEMT shall be provided only if the member does not have access to transportation that is available at no cost to the member. Members with their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. The following exclusions apply:

- a. Transportation to obtain services not covered by Iowa Medicaid;
- b. Transportation to providers that are not enrolled in Iowa Medicaid;
- c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
- d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
- e. Transportation to DME providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
- f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;
- g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical

Alternative Benefit Plan

transportation services; and
h. Emergency transportation.

NEMT does not require a prior authorization, but at least two-business day notice (code has extra details about how to calculate this- include?) for scheduled rides is preferred, with some exceptions allowed for urgent trips. For mileage reimbursement, the member must notify the broker the day of the trip and the driver must have a valid driver's license and insurance coverage on the vehicle at the time of transport.

Reimbursement for meals is allowed in situations in which:

- a. The transportation being provided spans the entire meal period;
- b. The one-way distance to or from the medical appointment is more than 50 miles;
- c. The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- d. The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to rule 11—41.6(8A) and is supported by detailed receipts.

Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

Transportation is provided to the closest qualified and enrolled Medicaid provider unless the difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or the additional cost of transportation to the enrolled provider requested by the member is medically justified based on the member's previous relationship with the requested provider, the member's prior experience with the requested provider, the requested provider's special expertise or experience, or a referral requiring the member to be seen by the requested provider.

Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

Members who engage in disruptive or unsafe behaviors may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

Other 1937 Benefit Provided:

Dental Coverage

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Other

Amount Limit:

See "Other"

Duration Limit:

Based on each service- see below

Alternative Benefit Plan

Scope Limit:

See "Other"

Other:

In addition to the limitations listed below, dental services are limited to one thousand dollars (\$1,000.00) per State Fiscal Year (July 1 – June 30). This limitation does not apply to the following services: preventive, diagnostic, emergency, anesthesia in conjunction with approved oral surgery codes or fabrication of removable dentures. The following limitations also apply to dental services but may be exceeded based on medical necessity. Enrollees under 21 years of age will be eligible for medically necessary dental services in accordance with federal EPSDT requirements.

1. Preventive Services

- a. Oral prophylaxis, including necessary scaling and polishing. Limitation: Once in a six month period except for persons who, because of physical or mental disability, need more frequent care.
- b. Topical application of fluoride. Limitation: Once in a 90 day period (this does not include the use of fluoride prophylaxis paste as fluoride treatment).
- c. Pit and fissure sealants. Limitation: Covered on first and second deciduous and permanent molars only for enrollees through 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

2. Diagnostic Services

- a. Comprehensive evaluation. Limitation: maximum of 1 every 3 years per dentist.
- b. Periodic evaluation. Limitation: maximum of 2 per 12 months, 6 months apart.
- c. Full mouth radiograph survey consisting of a minimum of 14 periapical films and bitewing films. Limitation: Once in a 5 year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and disease. Full mouth radiograph surveys are not payable under the age of six.
- d. Supplemental bitewing films. Limitation: Once in a 12-month period.
- e. Single periapical films, intraoral radiograph, occlusal, extraoral radiograph, posterior-anterior and lateral skull and facial bone radiograph, survey film, temporomandibular joint radiograph, and cephalometric film when medically necessary.

3. Restorative Services

- a. Treatment of dental caries in those areas which require immediate attention. Limitation: Restoration of incipient or nonactive carious lesions are not covered.
- b. Amalgam alloy and composite resin-type filling materials. Limitation: Once for the same restoration in a two-year period. An amalgam restoration is covered following a sedative filling in the same tooth only if the sedative filling was placed more than 30 days previously.
- c. Stainless steel crowns when a more conservative restoration would not be serviceable. Limitation: Stainless steel crowns with a resin window are limited to anterior teeth.
- d. Laboratory fabricated crowns. Prior Authorization is required. Limitation: Noble metals are limited to those persons who are allergic to other restorative materials.
- e. Cast post and core, post and composite or amalgam in addition to a crown. Limitation: Covered if a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

4. Periodontal Services- Full mouth debridement. Limitation: Once every 24 months and is not allowed on the same date of services when prophylaxis or other periodontal services are provided. Periodontal treatment procedures require prior authorization.

5. Endodontic Services- Covered when there is fair to good prognosis for maintaining the tooth. Endodontic retreatment requires prior authorization.

6. Orthodontic Services- Covered for a severe handicapping malocclusion. Prior authorization is required. Limitation: not covered for enrollees 21 years of age and over.

Alternative Benefit Plan

7. Implants- Covered when a conventional denture cannot be used due to missing significant oral structures as a result of cancer, traumatic injuries, or developmental defects such as cleft palate. Prior authorization is required.

Other 1937 Benefit Provided:

Adult Vision

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

One routine vision exam per benefit year

Scope Limit:

Not covered- surgery to correct a refractive error, eyeglasses or contact lenses including charges related to their fitting, prescribing of corrective lenses, eye examinations for the fitting of eye wear.

Other:

No prior authorization is required for exam.

Other 1937 Benefit Provided:

Dentures

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Other

Amount Limit:

See "Other"

Duration Limit:

Based on each service- see "Other"

Scope Limit:

See "Other"

Other:

Dentures, including repairs and adjustments are covered under the Medicaid state plan based on medical necessity and subject to the following limitations. The denture limitations described below may be exceeded based on medical necessity and with prior authorization.

- An immediate denture or a first-time complete denture including six months' post-delivery care when provided to establish masticatory function. Limitations: Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.
- Removable and fixed partial dentures require prior authorization. Limitation: A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.
- Replacement dentures. Limitation: Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five year period. Prior authorization may be



Alternative Benefit Plan

obtained if replacement is medically necessary prior to the expiration of the five-year period. Prior authorization is also allowed for more than one denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

d. Relines. Limitation: Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.

e. Tissue conditioning. Limitation: Covered twice per prosthesis in a 12-month period.

f. Repairs. Limitation: Only two repairs per prosthesis in a 12-month period.

g. Obturator. Limitation: For surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

h. Adjustments to a complete or removable partial denture. Limitation: If medically necessary after six months' post-delivery care.

Add



Alternative Benefit Plan

☐

15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808