

Comparison of Medicaid Basic Benefits Based on Eligibility Determination			
Service Category	Medicaid (Fee for Service)	Iowa Health and Wellness (IHAWP)	Hawki (Healthy and Well Kids in Iowa)
General Provisions			
Benefits Available from Out-of-Network Providers	Please contact Member Services to determine the requirements for using an out-of-network provider.	Please contact Member Services to determine the requirements for using an out-of-network provider.	Please contact Member Services to determine the requirements for using an out-of-network provider.
Cost Sharing: A variety of methods are used to share expenses between the state and a member. These methods include monthly cost shares, copays, and premiums	Variable copayments based on eligibility are not listed. Please contact Member Services for further details.	Variable copayments based on eligibility are not listed. Please contact Member Services for further details.	Variable copayments based on eligibility are not listed. Please contact Member Services for further details.
Copayments			
Persons over age 21, most services	\$1.00 to \$3.00 based on types of services	\$0.00	Not applicable
Persons receiving long-term care institutional	Based on family income level	Not applicable	Not applicable
Copayment Exceptions			
Family planning services or supplies regardless of age	\$0.00	\$0.00	\$0.00
Pregnant women, all services	\$0.00	\$0.00	\$0.00
Emergency services	\$0.00	\$0.00	\$0.00
Members under the age of 21	\$0.00	\$0.00	\$0.00
Members who are below 50% of the Federal Poverty Level (FPL)	\$0.00	\$0.00	\$0.00
Ambulatory Services			

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Primary Care Illness/injury Physician Services	Covered	Covered	Covered
Specialty Physician Visits	Covered	Covered, may require prior authorization	Covered, may require prior authorization
Home Health Services	Covered	Covered, Private Duty Nursing/Personal Care Services are only available to 19- and 20-year-olds through EPSDT.	Covered
Chiropractic Care therapeutic adjustive manipulative	Covered, limitations may apply	Covered, limitations apply	Covered, limitations apply
Outpatient surgery	Covered, may require a prior authorization	Covered, may require a prior authorization	Covered, may require a prior authorization
Second Surgical Opinion	Covered	Covered	Covered
Allergy Testing & Injections	Covered	Covered	Covered
Chemotherapy- Outpatient	Covered, may require a prior authorization	Covered, may require a prior authorization	Covered, may require a prior authorization
IV Infusion Services	Covered, may require a prior authorization	Covered, may require a prior authorization	Covered, may require a prior authorization
Radiation Therapy Outpatient	Covered	Covered	Covered
Dialysis	Covered	Covered as an inpatient or in a Medicare approved dialysis center (outpatient).	Covered
Anesthesia	Covered	Covered	Covered
Walk-in Centers	Covered	Covered	Covered
AIDS/HIV parity	Covered	Covered	Covered

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Access to clinical trials	Covered Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	Covered Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.	Covered Medical necessity will be determined on a case-by-case basis through the Prior Authorization process.
Genetic Counseling/Diagnostic Testing	Covered, may require a prior auth and limitations may apply.	Covered, Prior authorization required. Must be an appropriate candidate and outcome is expected to determine a covered course of tx and not just informational.	Covered, may require a prior auth and limitations may apply.
TMJ	Covered	Covered	Not Covered
Emergency Services			
Emergency Room Services	Covered; \$3.00 per visit for non-emergent medical services.	Covered; \$8.00 per visit for non-emergent medical services.	Covered; emergency services for non-emergent conditions are subject to a \$25 copay if the family pays a premium for the Hawki program.
Emergency Transportation-Ambulance and Air Ambulance	Covered, limitations may apply	Covered, limitations may apply	Covered, limitations may apply
Urgent Care Centers/Facilities Emergency Clinics (non-hospital)	Covered	Covered	Covered
Hospitalization			
Preapproval of inpatient admissions	Required for non-emergent admissions	Required for non-emergent admissions	Required for non-emergent admissions
General Inpatient Hospital Care	Covered	Covered	Covered

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Inpatient Physician Services	Covered	Covered	Covered
Inpatient Surgical Services	Covered	Covered	Covered
Non-Cosmetic Reconstructive Surgery	Covered, may require PA and may have limitations	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 complications resulting from noncovered cosmetic procedures.	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 complications resulting from noncovered cosmetic procedures.
Transplant Organ and Tissue	Covered, may require PA and may have limitations	Covered- certain bone marrow/stem cell transfers from a living donor, heart, heart/lung, kidney, liver, lung, pancreas, pancreas/kidney, small bowel. Not Covered- transport of living donor, services/supplies related to mechanical or non- human	Covered; limitations apply

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		organs, transplant services and supplies not listed in this section including complications.	
Congenital Abnormalities Correction	Covered, may require prior authorization	Covered, may require prior authorization	Covered, may require prior authorization
Anesthesia	Covered	Covered	Covered
Hospice Care - Inpatient & Outpatient	Covered, may have limitations	<p>Covered for terminally ill patient and have a life expectancy of six months or less.</p> <p>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.</p>	Covered

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Hospice Respite - Inpatient	Covered, may have limitations	Covered, Limited to fifteen (15) Days per lifetime for inpatient respite care. Fifteen (15) Days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than five (5) Days at a time.	Covered
Chemotherapy - Inpatient	Covered, may have limitations	Covered, may have limitations.	Covered, may have limitations
Radiation Therapy - Inpatient	Covered, may require a prior authorization	Covered, may require a PA.	Covered, may require a prior authorization
Breast Reconstruction	Covered with medical necessity.	Covered with medical necessity.	Covered; limitations may apply
Maternity & Newborn Care			
Maternity/Pregnancy Services - Pre & Postnatal Care - Delivery & Inpatient maternity - Nutritional	Covered	Enrolled Member is required to report pregnancy and eligibility for consideration of Benefits under the Medicaid State Plan. If length of stay is less than 48 or 96 hours, a follow-up postpartum home visit by an RN is covered.	Enrolled Member is required to report pregnancy and eligibility for consideration of Benefits under the Medicaid State Plan. If length of stay is less than 48 or 96 hours, a follow-up postpartum home visit by an RN is covered.
Tobacco Cessation for Pregnant Women	Covered	Covered	Covered
Midwife Services	Covered	Covered	Covered

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Newborn child coverage	Not covered under mother, would need to apply for coverage for newborn	Not covered under mother, would need to apply for coverage for newborn	Not covered under mother, would need to apply for coverage for newborn
Mental Health Behavioral Health Substance Abuse			
Assertive Community Treatment (ACT)	Covered	Covered	Not covered
Behavioral Health Intervention Services (BHIS), including applied behavior analysis	Covered	Covered; residential treatment** is not covered	Not covered
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment)	Covered (MCO members only)	Not covered	Not covered
Crisis Services	Covered	Covered; residential treatment** is not covered	Covered
Functional Family Therapy/Multi-Systemic Therapy	Covered	Covered for 19- to 21-year-olds	Covered
Inpatient mental health and substance abuse treatment	Covered	Covered; residential treatment** is not covered	Covered
Office visit	Covered	Covered	Covered
Outpatient mental health and substance abuse	Covered	Covered	Covered
Psychiatric Medical Institutions for Children (PMIC)	Covered	Covered	Not covered
Subacute Mental Health Services	Covered	Covered	Not covered

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Prescription Drugs			
Prescription Drugs	Covered, may require a prior authorization	Covered, may require a prior authorization	Covered, may require a prior authorization
Rehabilitative and Habilitative Services and Devices			
Physical Therapy, Occupational Therapy, Speech Therapy	Covered	<p>Rehabilitative speech therapy services are covered 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.</p> <p>Not Covered: Physical therapy and occupational therapy provided as an inpatient in the absence of a separate medical condition that</p>	Covered

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		<p>requires hospitalization.</p> <p>Speech therapy not provided by licensed or certified speech therapist.</p> <p>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.</p>	
Inhalation therapy	Covered	Limit of sixty (60) visits in a twelve (12) month period.	Covered
Medical and Surgical supplies	Covered, may have limitations	Non-covered- elastic stockings or bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription.	Covered, may have limitations

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Durable Medical Equipment	Covered, may have limitations and may require a prior authorization	Non-covered items include elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that are available for purchase without a prescription.	Covered, may have limitations
Orthotics	Covered, may require a prior authorization	Covered, may require a prior authorization	Covered, may have limitations and may require a prior authorization
Prosthetics	Covered, may require a prior authorization	Covered, may require a prior authorization	Covered, may require a prior authorization
Cardiac Rehabilitation	Covered, may have limitations	Covered, may have limitations	Covered, may require a prior authorization
Pulmonary Rehabilitation	Covered, may have limitations	Covered, may have limitations	Covered, may have limitations
Skilled Nursing Services	Covered, may require a prior authorization and may have limitations	Covered in nursing facilities, skilled nursing facilities and hospital swing beds	Covered, may have limitations
Laboratory Services			
Lab Tests	Covered, may require a prior authorization and may have limitations	Covered, may require a prior authorization and may have limitations	Covered, may require a prior authorization and may have limitations
X-Rays	Covered, may have limitations	Covered, may have limitations	Covered, may have limitations
Imaging/Diagnostics MRI CT PET	Covered, may require a prior authorization and may have limitations	Covered, may require a prior authorization and may have limitations	Covered, may require a prior authorization and may have limitations

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Sleep Studies	Covered, may have limitations	Covered, Treatment for snoring not covered. Claims must be for a diagnosis of sleep apnea	Covered, may have limitations
Sleep Apnea Devices	Covered for adults	Covered	Not covered
Pathology	Covered	Covered	Covered
Preventive Wellness Chronic Disease Management			
Preventive Care	Covered	Covered, may have limitations	Covered
Nutritional Counseling	Covered, may have limitations	Max forty (40) units allowed for twelve (12) month period	Covered, may have limitations
Counseling and Education Services	Covered, may have limitations	Limited Coverage. Does not include: Bereavement, family, or marriage counseling. Education other than diabetes.	Covered, may have limitations
Family Planning services or supplies regardless of age	Covered; limitations may apply	Covered; limitations may apply	Covered; limitations may apply

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Vision Care Exams (Adult)	Covered, one exam per year	<p>Only allowed once per year Not covered - Surgery to correct a refractive error, eyeglasses or contact lenses including charges related to fitting, prescribing of corrective lenses, eye examinations for the fitting of eye wear.</p> <p>This does not limit the medical exams for Enrolled Members. Medical exams should be coded properly for accurate claim adjudication.</p>	Covered, one exam per year
Eyeglasses	Covered	Covered for ages 19 to 20, limitations may apply.	Covered
Immunizations	Covered, may have limitations	Covered with exception to immunizations for travel.	Covered
Colorectal Cancer Screening	Covered, one exam per year	Covered, one exam per year.	NA
Screening Mammography	Covered, one exam per year	Covered, one exam per year.	Covered
Hearing Exam (Adult)	Covered, one exam per year	Covered, one exam per year Hearing aids not covered.	Covered, one exam per year
Hearing aids	Covered	Covered for ages 19 to 20, limitations may apply.	Covered; limitations may apply

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Diabetes - med necessary equip and supplies	Covered, may have limitations and may require a PA	Covered, may have limitations and may require a PA.	Covered, may have limitations and may require a PA
Diabetic Education	Covered, may have limitations	Covered, may have limitations.	Covered, may have limitations
Screening Pap tests	Covered	Covered	Covered
Gynecological exam	Covered	One (1) per year.	Covered
Prostate cancer screening	Covered	One (1) per year for men age fifty (50) to sixty-four (64) years.	Covered
Foot Care	Covered, must be medically necessary. Limitation may apply.	Must be related to medical condition, routine services are not covered.	Covered, must be medically necessary. Limitation may apply.
Tobacco Cessation	Covered	Treatment and medical eval for nicotine dependence.	Covered
Pediatric Services including oral & vision			
EPSDT	Covered for children up to age 21	Covered for ages 19-20	Not Covered
Acupuncture	Not Covered	Not covered	Not covered
Infertility Diagnosis	Covered, may require a PA and may have limitations	Not covered- infertility treatment resulting from voluntary sterilization, relating to collection/purchase of donor semen or eggs, freezing of the same, surrogate services, infertility diagnosis and tx, and tubal/vasectomy reversals, fertility drugs.	Not covered

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Infertility Treatment	Not Covered	Not covered	Not covered
Bariatric Surgery	Covered, may require a PA and may have limitations	Not covered	Covered; limitations may apply
Non-emergency Transportation Services	Covered, may have limitations	Not covered	Not covered
Breast Reduction	Covered with medical necessity	Not covered	Not covered
Long Term Services Supports (LTSS) - Community Based			
Case management (CM)/ Targeted Case Management (TCM)	CM is covered for the Home and Community Based Services (HCBS) Habilitation and Waiver populations only. TCM is covered for adults with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; and children who are eligible to receive HCBS intellectual disability waiver services or HCBS children's mental health waiver services.	Not covered	Case Management is covered
Childcare medical services	Covered	Not covered	Not covered

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Community-based Neurobehavioral Rehabilitation Services (CNRS)	Covered; Prior Authorization required	Residential treatment** covered only for members who are determined medically exempt, intermittent covered; Prior Authorization required	Not covered
Private duty nursing/Personal cares per EPSDT authority	Covered up to age 21 under EPSDT	Covered up to age 21 under EPSDT	Not covered
Section 1915(C) Home- and Community-Based Services (HCBS) Waiver Services	Covered	Not covered	Not covered
Section 1915(I) State Plan HCBS Habilitation Services	Covered	Covered only for members who are determined medically exempt	Not covered
Home health services: · Home health aid · Skilled nursing · Therapies (PT/OT/Speech)	Covered	Covered; limitations may apply	Covered

Long Term Services and Support (LTSS) – Institutional

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ICF/ID (Intermediate Care Facility for Individuals with Intellectual Disabilities)	Covered; limitations apply	Not covered; This facility type is also not covered for members who are determined medically exempt.	Not covered
Nursing Facility (NF) and Nursing Facility for the Mentally Ill (NF/MI)	Covered; limitations apply	Not covered; NF services are covered only for members who are determined medically exempt.	Not covered
Skilled Nursing Facilities (SNF)	Covered; limitations apply	Covered; limited to 120 days per rolling calendar year; SNF are covered with no limits for members who are determined medically exempt.	Covered; limitations apply
Special Population Skilled Nursing Facility Out of State (Skilled preapproval)	Covered; limitations apply	Not covered	Not covered

Coverage of the service does not guarantee automatic approval and may be subject to the prior authorization requirements for each health plan.

**An IHAWP member who has been determined by the Department to be medically exempt will be enrolled in the Medicaid State Plan benefit with the option to opt-out. IHAWP members with a medically exempt status will receive state plan benefits, as listed in the “Medicaid” column of this chart, unless otherwise noted. To be considered for medically exempt status, contact Member Services at 1-800-338-8366(Toll Free) or 515-256-4606 (Des Moines Area).*

***Residential treatment is considered treatment provided in a setting that provides room and board, personal assistance, and other essential daily living activities to three or more individuals who by reason of illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves but who do not require the services of a registered or licensed practical nurse except on an emergency basis.*