IOWA Health and Human Services

Iowa Health Link
Iowa HHS

Comparison of Medicaid Basic Benefits Based on Eligibility Determination			
	Medicaid	**Iowa Health and Wellness Plan (IHAWP) ***	**Hawki (Healthy and Well Kinds in Iowa)**
General Plan 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

Preventative Services			
Affordable Care Act (ACA) preventive services	Covered	Covered	Covered
Routine check-ups	Covered	Covered; limitations may apply	Covered
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered up to age 21	Covered up to age 21	Not covered
Immunizations	Covered	Covered; limitations may apply	Covered
Professional Office Services			
Primary care provider	Covered	Covered	Covered
Office visit	Covered	Covered	Covered
Allergy testing	Covered	Covered	Covered
Allergy serum and injections	Covered	Covered	Covered
Certified nurse midwife services	Covered	Covered	Covered
Chiropractor	Covered; limitations may apply	Covered; limitations may apply	Covered; limitations may apply
Contraceptive devices	Covered; limitations may apply	Covered; limitations may apply	Covered; limitations may apply
Dental Services	Covered	Covered	Covered
Diabetic self-management training	Covered	Covered	Covered

Family planning and family planning related services	Covered	Covered	Covered
Gynecological exam	Covered	Covered; limited to one visit per year	Covered
Injections	Covered; limitations may apply	Covered; limitations may apply	Covered; limitations may apply
Laboratory tests	Covered	Covered	Covered
Maternity Care (Pregnancy, Pre and Post Care, Birth, and Post Partum Coverage)	Covered	Covered	Covered
Newborn child - office visits	Covered	Covered	Covered
Podiatry	Covered; routine foot care is not covered unless it is part of a member's overall treatment related to certain health care conditions.	Covered; routine foot care is not covered unless it is part of a member's overall treatment related to certain health care conditions.	Covered
Routine eye exam *One routine vision exam per calendar year.*	Covered	Covered	Covered
Routine hearing exam *One routine hearing exam per calendar year.*	Covered	Covered	Covered
Temporomandibular joint (TMJ) Treatment	Not Covered	Covered	Not Covered
Specialist office visit	Covered; PCP referral may be required	Covered; PCP referral may be required	Covered; PCP referral may be required

Hospital Services			
Inpatient Hospital Admissions			
Preapproval of inpatient admissions	Required for non-emergent admissions	Required for non-emergent admissions	Required for non-emergent admissions
Inpatient Hospital Services			
Room and board	Covered	Covered	Covered
Inpatient physician services	Covered; includes anesthesia	Covered; includes anesthesia	Covered
Inpatient supplies	Covered	Covered	Covered
Inpatient surgery	Covered	Covered	Covered
Bariatric surgery for morbid obesity	Covered	Not covered	Covered; limitations may apply
Breast reconstruction, following breast cancer and mastectomy	Covered	Covered	Covered; limitations may apply
Organ/bone marrow transplants	Covered; limitations apply	Covered; limitations apply	Covered; limitations apply
Outpatient Hospital Services			
Abortions	Certain circumstances must apply. Contact Member Services. Prior authorization required.	Certain circumstances must apply. Contact Member Services. Prior authorization required.	Covered; certain circumstances must apply. Contact Member Services. Prior authorization required.
Ambulatory surgical center	Covered; includes anesthesia	Covered; includes anesthesia	Covered; includes anesthesia
Chemotherapy	Covered	Covered	Covered

Dental treatment that cannot be completed in a normal dental office setting	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Outpatient diagnostic lab, radiology	Covered	Covered	Covered
Emergency Care			
Ambulance	Covered	Covered	Covered
Urgent care center	Covered	Covered	Covered; may require prior authorization
Hospital emergency room	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
Non-Emergency Medical Transportation (NEMT)	Covered	Not covered	Not covered
Behavioral Health Services			
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,	Covered (MCO members only)	Not covered	Not covered

peer support, and residential substance use treatment)			
Crisis Services	Covered	Covered; residential treatment** is not covered	Covered, limitations may apply.
Functional Family Therapy/Multi-Systemic Therapy	Covered	Covered for 19- to 21-year-olds	Not 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 for 19- to 21-year-olds. Limitations may apply	Not covered
Subacute Mental Health Services	Covered	Not Covered	Not covered
Outpatient Therapy Services			
Cardiac rehabilitation	Covered; prior authorization may be required	Covered	Covered; prior authorization may be required
Occupational therapy	Covered; prior authorization may be required	Limited to 60 visits per year	Covered; prior authorization may be required
Oxygen therapy	Covered; prior authorization may be required	Limited to 60 visits in a 12-month period	Covered; prior authorization may be required
Physical therapy	Covered; prior authorization may be required	Limited to 60 visits per year	Covered; prior authorization may be required

Pulmonary therapy	Covered; prior authorization may be required	Limited to 60 visits per year	Covered; prior authorization may be required
Respiratory therapy	Covered; prior authorization may be required	Limited to 60 visits per year	Covered; prior authorization may be required
Speech therapy	Covered; prior authorization may be required	Limited to 60 visits per year	Covered; prior authorization may be required
Prescription Drug Coverage			
Quantity	Optional 90-day supply for a select list of generic, maintenance prescription medications and contraceptives. To view this list, please visit www.IowaMedicaidPDL.com. 31-day supply for all other prescriptions.	Optional 90-day supply for a select list of generic, maintenance prescription medications and contraceptives. To view this list, please visit www.IowaMedicaidPDL.com. 31-day supply for all other prescriptions.	Optional 90-day supply for a select list of generic, maintenance prescription medications and contraceptives. To view this list, please visit www.IowaMedicaidPDL.com. 31-day supply for all other prescriptions.
Covered Prescription and nonprescription drugs	Covered; $1.00 copay	Covered; $0.00 copay	Covered; $0.00 copay
Prescription and nonprescription drugs for smoking cessation	Covered	Covered	Covered
Radiology Services			
Mammography	Covered	Covered	Covered
Routine radiology screening and diagnostic services	Covered	Covered	Covered
Sleep study testing	Covered	Covered	Covered
Laboratory Services			
Colorectal cancer screening	Covered	Covered	Covered

Diagnostic genetic testing	Covered	Covered; Prior Authorization required	Covered
Pap smears	Covered	Covered	Covered
Pathology tests	Covered	Covered	Covered
Routine laboratory screening and diagnostic services	Covered	Covered	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing	Covered	Covered	Covered
Durable Medical Equipment (DME)			
Medical equipment and supplies	Covered	Covered	Covered
Diabetes equipment and supplies	Covered	Covered; limitations may apply	Covered
Eyeglasses	Covered; limitations may apply	Covered for ages 19 to 20, limitations may apply	Covered; limitations may apply
Hearing aids	Covered	Covered for ages 19 to 20, limitations may apply	Covered; limitations may apply
Orthotics	Covered; limitations may apply	Covered	Covered; limitations may apply and Prior authorization required
Sleep apnea device	Covered for adults	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.	Not covered	Case Management is covered

	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		
Childcare medical services	Covered	Not covered	Not covered
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			
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
Hospice			
Daily categories: • Routine care *If member is residing in a Nursing Facility, room and board charges covered at 95%* • Facility respite • Inpatient hospital • Continuous	Covered	Covered; limitations apply	Covered
Health Homes			

Integrated Health Homes	Covered	Covered only for members who are determined medically exempt	Not covered

**An IHAWP member who has been determined by the Department to be medically exempt shall be given the choice of benefits and service delivery method provided by the IHAWP plan or receiving benefits and services pursuant to Medicaid. Form 470-5194[1] or 470-5196 must be completed for the Department to determine if a member is exempt. IHAWP members with a medically exempt status will receive state plan benefits, as listed in the "Medicaid" column of this chart, unless otherwise noted.*

***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.*

[1] https://hhs.iowa.gov/media/5841/download?inline