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State/Territory Name: Iowa

State Plan Amendment (SPA) #: 23-0026

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS Form 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

February 23, 2024

Elizabeth Matney
Medicaid Director
Iowa Department of Human Services
1305 East Walnut Street
Des Moines, IA 50319

Re: Iowa State Plan Amendment (SPA) 23-0026

Dear Iowa Medicaid Director Matney:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0026. This amendment proposes to comply with the federal requirement that the state implement a tracking system that ensures that cost sharing and premiums of a Medicaid beneficiary will not exceed five percent of the family income.

We conducted our review of your submittal according to statutory requirements in Title 1916A of the Social Security Act and implementing regulation Section 42 C.F.R. subsection 447.57. This letter is to inform you that Iowa Medicaid SPA 23-0026 was approved on February 23, 2024, with an effective date of January 1, 2024.

If you have any questions, please contact Lee Herko at 570-230-4048 or via email at Lee.Herko@cms.hhs.gov .

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Jennifer Steenblock
Jeanette Brandner

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Iowa**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

IA-23-0026

Proposed Effective Date

01/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1916A of the Social Security Act and 42 CFR 447.57

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	24	$ 0.00
Second Year	25	$ 0.00

Subject of Amendment

Cost Sharing - ensure compliance with the federal requirement that Medicaid premiums and cost sharing by all individuals in the Medicaid household do not exceed an aggregate limit of 5% of the family's monthly income.

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**
  Describe:
- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:	**Jennifer Steenblock**
Last Revision Date:	**Feb 15, 2024**
Submit Date:	**Nov 29, 2023**

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 09381148

Transmittal Number: IA - 23 - 0026

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☒ Other process

Description:

MCOs are contractually required to make this information available to providers for their members. The Iowa Department of Health and Human Services (HHS) reviews and approves the MCO's methodology. HHS also provides information regarding copayments for the fee-for-service population through provider education materials such as the HHS Medicaid Provider Policy Manual.

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- ■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- ■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- ■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

"Non-emergency care" would be defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. Hospital ER staff will make this determination, and it will become part of the EMTALA screening. If ER staff (medical professional at the hospital) determines the condition to be non-emergent, they will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available.

If the individual still opts to be treated at the ER, they will be required to pay the $3 co-pay (for regular Medicaid) and $8 (for IHAWP) for non-emergent care in the ER. The deduction of the copay by Iowa Medicaid will be determined based on the diagnosis codes submitted on the claims. Providers will be instructed in the Informational Letter (IL) that any claim lacking an emergent diagnosis code, but where the "prudent layperson" determination by hospital staff was "appeared emergent", the provider is directed by the state to contact Iowa Medicaid to have the claim handled through the existing Provider Inquiry process to be adjusted to pay without deducting the copay. This requirement will be announced to all hospitals by IL and post-pay review sample of claims will be used to ensure provider compliance with these requirements.

Members have appeal rights for virtually any "adverse action", which a member believes to have occurred, and that would be the case here as well.

The foregoing "approach" has been communicated with hospitals, via their statewide association, and, the state will issue corresponding Informational Letters to reinforce these requirements.

Cost Sharing for Drugs

The state charges cost sharing for drugs.	Yes
The state has established differential cost sharing for preferred and non-preferred drugs.	No

- ■ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

V.20160722

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 09381148

Transmittal Number: IA - 23 - 0026

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☒ Other procedure

Description:

If an applicant answers yes to the following question on the single streamlined application, cost-sharing is waived: "Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?"

Additionally, the following procedures are in place to identify the AI/AN exemption:
• Information collected within the Eligibility & Enrollment (E&E) system, based on what the applicant indicates on the single streamlined application.
• Information is passed to post-E&E systems, which are the Title XIX (TXIX) and Medicaid Management Information System (MMIS) systems;
> TXIX – Receives eligibility information from E&E systems and generates eligibility files that are passed to MMIS.
> MMIS – Eligibility information is updated into the Recipient data of the MMIS, which enables the MMIS to set a flag.
• MMIS then uses this internally for setting the appropriate flags to insure that an applicant's cost-sharing is waived, when appropriate under these circumstances involving AI/AN.
• This information is made available to providers, via ELVS and the online electronic eligibility (HIPAA-compliant) portal.
• For members enrolled in an MCO, the member eligibility information is passed to the MCOs from the MMIS.

Additional description of procedures used is provided below (optional):

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

MCOs are required to develop mechanisms, subject to State review and approval, to identify individuals exempt from cost sharing.

The Eligibility & Enrollment (E&E) system passes the flags to the post-eligibility systems in the same way that it does so for the AI/AN exemption.

Additional description of procedures used is provided below (optional):

Relative to identifying all other individuals exempt from cost-sharing by use of a list of procedures, including MMIS flags, to identify members exempt from cost-sharing AND what triggers those flags in MMIS, different copay exemptions would be triggered differently, related to each exemption. For instance, for exemptions related to receipt of family planning services, an "FP" indicator is used, which identifies the service as being exempt from cost-sharing because it involves FP services. In cases of copays not being charged for children under 21 years of age, the "flag" would be tied to system logic which calculates the member's age by the birthdate on file for that member.

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ○ Quarterly
- ◉ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☒ Managed care organization(s) track each family's incurred cost sharing, as follows:

The eligibility system calculates the 5% cost sharing limit based on household size and income. This is then sent via a daily file to the MMIS which transmits the data to the MCOs. MCOs send daily files to the MMIS identifying all copayments applied. The MMIS then tracks and accumulates cost sharing totals, inclusive of premiums and copayments. If the 5% limit is reached, notification is sent to the enrollee informing them the cost sharing limit has been met and no additional cost sharing will be applied. This is sent by the MCO for managed

care enrollees and MMIS for fee-for-service (FFS). The MCO then updates claims processing for the remainder of the month to ensure the copayment is not deducted. The MMIS completes the same for FFS claims.

☐ Other process:

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Once the aggregate family limit has been met, the MCO (for managed care) or MMIS (for FFS) sends notice to the beneficiary that the limit has been met and cost sharing will not apply for the remainder of the month. Providers are informed through the eligibility verification systems.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

Managed care enrollees may bring receipts to the MCO and fee-for-service beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have paid cost-sharing in excess of the aggregate limit for the month. The MCO or Medicaid agency, as applicable, will review the receipts and reprocess any claims in which excess cost sharing was charged to the member or beneficiary. The MCOs and Medicaid agency also provide additional guidance to providers informing them that if a copay was collected, the provider is required to process a reimbursement of that cost sharing amount to the beneficiary.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Managed care members may bring receipts to the MCO and fee-for-service beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have paid cost-sharing in excess of the aggregate limit for the month. The MCO or Medicaid agency, as applicable, will review the receipts and reprocess any claims in which excess cost sharing was charged to the member or beneficiary. The MCOs and Medicaid agency also provide additional guidance to providers informing them that if a copay was collected, the provider is required to process a reimbursement of that cost sharing amount to the beneficiary.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, beneficiaries may notify the Medicaid agency of a change in their income or other circumstance that might change their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change the aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

V.20160722