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State/Territory Name: Iowa

State Plan Amendments (SPA) #: IA-16-0025

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

JUL 0 8 2016

Mikki Stier, Director
Division of Medical Services
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315

Dear Ms. Stier:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), IA-16-0025-CHIP, submitted on April 27, 2016 has been approved. This SPA updates the state plan to reflect changes related to the managed care delivery system and other conforming changes, such as updates regarding strategic objectives and performance goals, the quality and appropriateness of care, and appeals and grievances procedures. The retroactive effective date for this SPA is April 1, 2016.

Your title XXI project officer is Ms. Kristin Edwards. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Edwards' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
Facsimile: (410) 786-5882
E-mail: kristin.edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. James Scott, Associate Regional Administrator (ARA) in our Kansas City Regional Office. Mr. Scott's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Richard Bolling Federal Building
601 East 12th Street, Room 355
Kansas City, MO 64106-2808

If you have additional questions, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs at (410) 786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Anne Marie Costello
Director

Enclosure

cc: Mr. James Scott, Associate Regional Administrator, Region VII

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Iowa
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))
Terry E. Branstad, Governor
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Charles. M. Palmer Position/Title: Director, Iowa Department of Human Services
Name: Mikki Stier, MSHA, FACHE Position/Title: Medicaid Director

Name: Deborah Johnson~~Robert Schlueter~~ Position/Title: Chief, Bureau Medical and Long Term Services and Supports ~~of Adult and Children's Medical Programs~~

*Disclosure. 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 0938-0707. The time required to complete this information collection is estimated to average 80 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered

under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
  - 1 (General Description)
  - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be

required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

Medicaid Expansion (M-CHIP)

Effective July 1, 1998

- Children ages 15 through 18 in families with income between 37 percent and 100 percent of Federal Poverty Level (FPL). These are the "Waxman" children that are being phased-in to Medicaid as a mandatory coverage group. Beginning October 1, 2002, all of these children will be covered under Medicaid.
- Children ages 6 through 18 in families with income that is equal to or less than 133 percent of FPL.

Effective July 1, 2000

Infants, up to one year of age, in families with income between 185 percent and 200 percent of FPL.

Effective July 1, 2009

When determining eligibility for infants, up to one year of age, all income between 185 percent and 300 percent of FPL shall be disregarded.

The State has implemented systems changes that allow for identification of children eligible for

Medicaid via CHIP so they can be reported separately from children eligible for Medicaid via the 1902(r)(2) Medicaid State Plan Amendment. This will allow CHIP eligible children (optional targeted low-income children) to be reported and claimed at the enhanced rate and other newly eligible children to be reported and claimed at the State's standard FMAP.
Children eligible for Medicaid as a result of the expansion receive health care services through the same delivery systems that operate in the Medicaid program.

Separate Program: Healthy And Well Kids In Iowa (hawk-i) Program (S-CHIP)
The Healthy And Well Kids in Iowa (hawk-i) program covers targeted low-income children up to age 19 in families who income does not exceed 200 percent of the FPL.
Effective January 1, 1999, the State implemented the hawk-i program for targeted low-income children up to age 19 in families who income was at or below 185% of the Federal Poverty Level (FPL). The State expanded coverage to 200% of the FPL effective July 1, 2000.
Effective July 1, 2009, when determining eligibility, all income between 200 percent and 300 percent of the FPL shall be disregarded.
The hawk-i program has several components and is designed to encompass a variety of entry points into the program. The delivery of services follows a private sector commercial insurance model.
Iowa Department of Human Services: The Department of Human Services (DHS) has been designated as the State agency to administer the hawk-i program.
hawk-i Board. The Iowa General Assembly authorized the creation of the hawk-i Board to provide direction to the Department of Human Services and to establish policy for the program. The hawk-i Board is made up of eleven members:

- Director of the Iowa Department of Public Health or their designee
- Director of the Iowa Department of Education or their designee
- Commissioner of the Iowa Division of Insurance or their designee
- Four Governor-appointed public members
- Four ex-officio legislators (2 Senate/2 House of Representatives)

Third Party Administrator: The Department of Human Services has contracted with a third party administrator to provide, at a minimum, the following services:

- Distribute applications
- Determine eligibility
- Screen for Medicaid eligibility and coordinate with co-located Medicaid eligibility workers.
- Calculate, bill, and collect cost sharing.
- Assist the family in selecting a health plan and enrolling the child in the selected plan.
- Provide DHS with demographic, statistical, and encounter data for federal reporting and other reporting requirements.

Advisory Committees: Two advisory committees have been established to provide input to the hawk-i Board. The Clinical Advisory Committee is made up of health care professionals who advise the hawk-i Board on issues around benefits, access, and quality. The Children With Special Health Care Needs Advisory Committee is made up of health care professionals and advocates who advise the hawk-i Board on health care issues faced by children with special needs and make recommendations on how to address those needs.

• Health and Dental Plans: The Department of Human Services contracts with ~~health and~~ dental plans licensed by the Division of Insurance within the Department of Commerce to provide ~~health and~~ dental care coverage to eligible children under the hawk-i program. Additionally, the Department of Human Services conducts a competitive procurement under the Iowa High Quality Healthcare Initiative to contract with managed care organizations (MCOs), which are required to be HMOs licensed in Iowa, to deliver all medical benefits to hawk-i enrollees.

• External Quality Review Organization (EQRO): ~~The University of Iowa Public Policy Center:~~ The Department of Human Services contracts with an EQRO to conduct an independent analysis and evaluation of the quality, timeliness and access to health care services provided by the MCOs. ~~with the University of Iowa Public Policy Center to conduct analysis of the functional health assessment and analysis of the encounter data. Effective July 1, 2005, the Department of Human Services will contract with the Telligen (formerly Iowa Foundation for Medical Care) to conduct the analysis of the functional health assessment and analysis of the encounter data.~~

1.1-DS ☒ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 1,1998

Implementation Date: July 1, 1998

SPA #IA-156-0025 CHIP25
~~18 Modified Adjusted Gross Income (MAGI) Eligibility and Methods (Attachment 18)~~
~~SPA #19 MAGI Medicaid Expansion Income Standards (Attachment 19)~~
~~SPA #20 Establish 2101f Group (Attachment 20)~~
~~SPA #21 MAGI Eligibility Process (Attachment 21)~~
~~SPA #22 Non-Financial Eligibility (Attachment 22)~~
~~SPA #23 Use of Health Service Initiatives to help fund the Iowa Poison Control Center~~

~~SPA # IA -15-0024~~
Purpose of SPA: Implement managed care delivery system. ~~Revising CS27 to include obtaining Medicaid eligibility as an exception to a 12-month enrollment.~~ ~~Updating federal poverty levels that require a premium to the new Modified Adjusted Gross Income (MAGI).~~

Proposed effective date: ~~July 1, 2014~~April 1, 2016 for implementation of managed care delivery system. ~~July 1, 2015 for revision of CS27~~.

Proposed implementation date: ~~July 1, 2014~~April 1, 2016 for implementation of managed care delivery system. ~~July 1, 2015 for revision of CS27~~.

Superseding Pages of MAGI CHIP State Plan Material

State: Iowa

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
IA-13-0018 **Effective/ Implementation Date: January 1, 2014**	MAGI Eligibility & Methods	CS7 CS12 CS15	Eligibility – Targeted Low Income Children Eligibility-Supplemental Dental Only MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Supersedes the current Section 4.1-DS Incorporate within a separate subsection under section 4.3
IA-13-0019 **Effective/ Implementation Date: January 1,**	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
2014				
IA-13-0020 **Effective/ Implementation Date: January 1, 2014**	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
IA-13-0021 **Effective/ Implementation Date: October 1, 2013**	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
IA-13-0022 **Effective/ Implementation Date: January 1, 2014**	Non-Financial Eligibility	CS17	Residency	Supersedes the current section 4.1.5
		CS18	Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	Supersedes the current section 8.7
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
		CS28	Presumptive Eligibility for Children	Supersedes the current section 4.3.2

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

~~No comments were received.~~ ~~TO BE COMPLETED PENDING CONSULATION~~

No comments were received.

TN No: Approval Date Effective Date

Section 2. **General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Historically, Iowa is a rural, agricultural state. However, recently there has been a shift in population from rural areas to urban centers. New estimates from the U.S. Census Bureau show that population growth in Iowa during the 2000's is confined to two areas: in and around Des Moines, and in theDavenport area . At the same time, 45 of Iowa's 99 counties are losing population. Data from 2010 suggests that 61percent of Iowans live inside a metropolitan area.

According to the 2010 U.S. Census, Iowa has a population of 3,046,355 with 26.9% (819,469) being children ages 19 and younger. The Census reports show 12.8% of Iowa's population or 389,933people living below poverty. In general, the highest levels of poverty are in the southern counties along the Missouri border.

While approximately 2,747,818 ((88.7%) of Iowa's population are white and 61,423 (4.1%) are black, Iowa is experiencing an ever-emerging diverse population. For Iowa's children ages 19 years and younger, the percentages of different races varies from the total population. The children are 80% white, 4.1% black or African American, 0.3% American Indian or Alaska Native, 2% are of other race and 3.4% are two or more races. There are63,207Hispanic children (can be of any race) in Iowa.

Additionally, Iowa is becoming home to more and more refugees from all areas of the world. Most recently, Iowa has had significant numbers of Sudanese and Bosnians settle in some of the larger urban

centers of the State.

Estimate Number of Refugees and Amerasians in Iowa

Region of Origin	Number Who Originally Settled in Iowa
Africa	
Sudanese	1,716
All other ethnicities	2,547
Near East	
Iraqi	594
All Others	128
Former Soviet Union	
All ethnicities	220
Eastern Europe	
Bosnian	7,915
Kosovar	191
All other ethnicities	117
Southeast Asia	
Vietnamese	1746
Tai Dam	11
Lowland Lao	115
Cambodian/Khmer	17
Hmong	26
Latin America/Caribbean	
Haitian	6
All other ethnicities	40
TOTAL	15,389

The Mesquaki Tribe is the only Federally recognized Native American Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi and Iowa Tribe and currently has 1,349 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, have resulted in a significant growth trend and 87% birth rate increase since 2010. According to the 2010 U.S. Census, 14,043 people identified themselves as Native American or Alaska Native. Of this number 39.6% are 19 years of age or younger.

The only public health insurance program generally available in Iowa is Medicaid. In February 2013, there were256,506children receiving coverage through the Medicaid program.

The Iowa Caring Program for Children, a primarily privately funded, Wellmark (Blue Cross Blue Shield of Iowa and South Dakota) sponsored program, covered about 3,000 children below 133% of FPL. This program covered uninsured children who did not qualify for Medicaid. With the expansion of Medicaid and implementation of the hawk-i program, the Caring Program ceased their program operations on July 1, 1999.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives**- Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

The State will use the health service ~~initiatve~~initiative option for those children found presumptively eligible for Medicaid who are later found to be hawk-i eligible. The health services initiatives will only be used for those services covered under Medicaid that are not covered under CHIP (hawk-i).

Iowa will use the health service initiative option allowed at 42 CFR 457.10 to support the Iowa Poison Control Center (IPCC). Poison treatment advice and prevention will be supported. Poison ~~treatement~~treatment advice through the IPCC will be supported using CHIP funds available under the 10 percent federal administrative expenditures cap. IPCC will not supplant or match CHIP HSI Federal funds with other Federal funds, nor allow Federal funds to supplant or match CHIP Federal Funds.

The Iowa Poison Control Center (IPCC) provides immediate access to expert treatment advice and assistance over the telephone in case of exposure to poisonous or hazardous substances. A single toll-free telephone number allows for rapid and direct access to highly specialized care for all Iowans including demographic populations that are typically underserved or lack access to high-quality health care, such as uninsured, low-income, immigrant families and individuals living in rural areas. Services are available 24 hours a day, seven days a week at no direct cost to the people who call. Translators are available in 150 languages through the language line.

The IPCC is contacted for all kinds of poisonings and overdoses affecting people of all ages: household products, medicines, pesticides, plants and mushrooms, bites and stings, food poisoning, and fumes. Public education is another crucial function of the IPCC and serves the dual role of promoting poison prevention behaviors and delivering outreach messages meant to foster awareness and utilization of PCC services. IPCC is staffed by nurses, pharmacists and physicians and other poison information providers who are specially trained in toxicology.

Nearly 26,000 poisoning exposure calls are received annually by IPCC (25,819 in CY 2013). Sixty-three percent involve a child under the age of 19. In addition to calls regarding exposures, the IPCC

receives between 15,000-20,000 calls each year for poison or drug information. These calls are considered preventive.

More than 80% of the cases involving children under age 19 are managed entirely at home with telephone guidance from the IPCC avoiding unnecessary and costly emergency department visits and ambulance runs. An estimated 46% of callers are covered by Medicaid which saves the Iowa's Medicaid program $5.7 million annually. The IPCC estimates the number of children on the Medicaid program or the Healthy and Well Kids in Iowa (hawk-i) program by conducting continuous randomized satisfaction surveys of callers in which it is also determined what type of health insurance they have. This percentage is significantly higher than Iowa's total Medicaid and CHIP enrollment due to a combination of enhanced IPCC partnerships and targeted community-based outreach strategies for reaching low-income families. Increased awareness of IPCC services will help improve access to uninsured, low-income children and reduce unnecessary ER visits saving the federal and state governments millions of dollars.

The IPCC has a long history of working closely with Head Start, Community Health Centers, WIC programs and physician clinics to reach the eligible population. Materials are also distributed through hospitals, health fairs, community and church groups, SAFE Kids coalitions, PTAs, school nurses, and classes for babysitters and new parents. Over 100,000 poison prevention materials are distributed each year throughout Iowa including brochures, phone stickers, magnets, posters, teacher packets, videos and other pieces. Culturally and linguistically appropriate learning materials are available in English, Spanish and Vietnamese. Newspaper, television, radio, IPCC website and social media also assist in communicating vital information.

A realistic and conservative study performed by the IPCC in 2013 showed that for every $1 invested in the poison center, $16.6 are saved in health care costs (Return on Investment of 16.6 to 1). An article published in the Journal of Medical Toxicology in 2008 stated that the ROI for the poison center that published the article was 36 to 1. If the IPCC applied the same methodology used in the 2008 article to our 2013 data, the IPCC's ROI would increase to 53:1. A 2012 report by the independent Lewin Group determined that the return on investment for the Federal government alone is substantial, billions of dollars each year, due to reduced Medicare, Medicaid and SCHIP costs.

The IPCC is an independent, not-for-profit 501(c)(3) organization. In recognition of its high quality, the IPCC is accredited by the American Association of Poison Control Centers. The center has been historically reliant on a tenuous patchwork of funding made up of primarily state and federal grants and support from sponsoring organizations UnityPoint Health and University of Iowa Hospitals and Clinics. Available funds within this patchwork have not kept pace with lean current operations and, in fact, have been cut substantially in recent years. In 2013, the IPCC launched a hospital subscription program which now comprises 25% of its total operating revenues. The IPCC still faces a significant budget deficit due to expiring grants and discontinuation of open-ended sponsor support. IPCC's current shortfall includes a funding gap of over $600,000 and faces closure without CHIP funding.

IPCC has been an outstanding example of how a public-private partnership can work in the state. CHIP funding will allow this organization to continue its strong track record of providing the residents of the

State of Iowa access to valuable, cost-effective, and life-saving services.

Iowa will only utilize administrative cap money to help fund the IPCC through the Iowa Department of Public Health (IDPH). No federal funds will be claimed for HSI activities that took place before the effective date of the SPA or prior to CHIP funds being incurred for approved costs. These funds will be used to help offset the cost for treatment of low income children. A statement of expenditures, which include both the state share of expenses paid for by the Department of Public Health and the federal share of funds to be passed through the Department of Human Services (DHS), will be submitted to DHS to request reimbursement. The funds will be drawn from the Payment Management System and deposited into DHS accounts. These funds will then be transferred internally to the Department of Public Health as a reimbursement of the federal share of expenses. IDPH is the entity that is authorized by the Iowa Legislature to receive state funds for the IPCC. IDPH and IPCC will not supplant or match CHIP federal funds with other federal funds, no allow other federal funds to supplant or match CHIP federal funds.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

The State using the same process as Iowa Medicaid consulted with Indian tribes and organizations regarding the movement to managed care organizations for CHIP. The State received no comments.

~~TO BE COMPLETED FOLLOWING TRIBAL CONSULTATION~~~~The State using the same process as Iowa Medicaid consulted with the Indian tribes and organizations regarding use of health service initiatives to help fund the Iowa Posion Control Center. The State received no comments. .~~

Section 3. Methods of Delivery and Utilization Controls

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

DHS has entered into risk comprehensive contracts with managed care organizations (MCO) to deliver services to CHIP enrollees. MCOs receive a monthly capitation payment for each enrollee. MCOs are licensed as health maintenance organizations (HMOs) in Iowa and must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC. Enrollment is voluntary for American Indian/Alaskan Native (AI/AN) populations. All other CHIP enrollees must enroll with an MCO.

To permit member choice, the State contracts with a minimum of two MCOs which provide statewide coverage. The MCOs develop a comprehensive provider network and must coordinate care for enrollees.

MCOs cover all services under the benchmark equivalent benefit package, with the exception of dental benefits. Effective July 1, 2003, the Iowa legislature passed legislation that allows dental only carriers to participate in the hawk-i program. Effective July 1, 2009, hawk-i dental services are provided through a separate dental plan, Delta Dental of Iowa.

A child shall remain enrolled in an MCO and dental plan for a twelve month period unless:
- A request for disenrollment from the MCO/dental plan is made at any time for cause. The for cause reasons are outlined in the MCO contracts and apply across all populations enrolled in Health Link, including Medicaid enrollees receiving long term services and supports. For purpose of disenrollment, "cause" includes: (1) member moves out of the service area; (2) MCO does not, because of moral or religious objections, cover the services the member seeks; (3) the member needs related services to be performed at the same time, and not all related services are available within the network and the member's provider determines that receiving the services separately would subject the member to unnecessary risk; (4) when a provider disenrolls from the MCO and this termination would result in disruption to the member's residence or employment (applicable to Medicaid LTSS enrollees); or (5) other reasons, including but not limited to, poor quality of care(e.g., failure of the MCO to assist with finding a network provider when requested or failure to respond to a reported critical incident);, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.
- A request for disenrollment from the MCO/dental plan is made without cause during the 90 days following the date of initial enrollment or when the third party administrator sends the notice of enrollment to the enrollee, whichever is later.

A child may disenroll from an MCO or dental plan at least every 12 months at the time of renewal.

DHS has entered into risk-comprehensive contracts with managed care organizations (MCO) to deliver services to CHIP enrollees. MCOs receive a monthly capitation payment for each enrollee. MCOs are licensed as health maintenance organizations (HMOs) in Iowa and must attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC. Enrollment is voluntary for American Indian/Alaskan Natives (AI/AN) populations. All other CHIP enrollees must enroll with an MCO.

To permit member choice, the State contracts with a minimum of two MCOs which provide statewide coverage. The MCOs develop a comprehensive provider network and must coordinate care for enrollees.

MCOs cover all services under the benchmark equivalent benefit package, with the exception of dental benefits. Effective July 1, 2003, the Iowa legislature passed legislation that allows dental only carriers to participate in the hawk-i program. Effective July 1, 2009, hawk-i dental services are provided through a separate dental plan, Delta Dental of Iowa.

A child shall remain enrolled in an MCO and dental plan for a twelve-month period unless:
• A request for disenrollment from the MCO/dental plan is made at any time for cause;
• A request for disenrollment from the MCO/dental plan is made without cause during the 90 days following the date of initial enrollment or when the third party administrator sends the notice of enrollment to the enrollee, whichever is later;
• There is a substantial change in the provider network of the MCO/dental plan originally chosen. A substantial change is determined by the hawk-i Board and includes, but is not limited to, loss of a contracted hospital or provider group. The child may disenroll from the current MCO or dental plan under these circumstances and enroll in another MCO or dental plan for the remainder of the twelve-month period.

A child may disenroll from an MCO or dental plan at least every 12 months at the time of renewal.

Healthy And Well Kids in Iowa (hawk-i) Program
The State has entered into contractual agreements with commercial insurers to provide a benchmark equivalent benefit package to enrollees in the hawk-i program. The insurer will provide the enrollee with a health plan card identifying them as an enrollee in that health plan. The enrollee will have a primary care physician if they are in a managed care plan.

Both indemnity and managed care plans are allowed to participate in the program. The goal is to allow choice among plans so that enrollees can select the health plan from which they want to receive coverage. Both indemnity and managed care plans receive a monthly capitation payment for each hawk-i enrollee in the plan. The State contracts with indemnity plans only in those counties where the State does not have a contract with a managed care plan. If the State enters into a contract with a managed care plan in a county where the State currently has a contract with an indemnity plan, the hawk-i enrollees of the indemnity plan shall remain enrolled with the indemnity plan until the expiration of the twelve-month enrollment. All enrollees eligible for the hawk-i program after the execution of the contract with the managed care plan shall be enrolled with the managed care plan.

~~Effective July 1, 2003, the Iowa legislature passed legislation that allows dental only carriers to participate in the hawk-i program. Effective July 1, 2009, hawk-i dental services are provided through a separate dental plan, Delta Dental of Iowa. Participating health plans are no longer offering dental coverage.~~

~~A child shall remain enrolled in a health and dental plan for a twelve-month period unless:~~
~~• a request for disenrollment from the plan is made at any time for cause;~~
~~• a request for disenrollment from the plan is made without cause during the 90 days following the date of initial enrollment or when the third party administrator sends the notice of enrollment to the enrollee whichever is later;~~
~~• there is a substantial change in the provider network of the health or dental plan originally chosen. A substantial change is determined by the hawk-i Board and means, but is not limited to, loss of a contracted hospital or provider group. When there is another participating health or dental plan available in the child's county of residence, the child may disenroll from the current health or dental plan and enroll in the other health or dental plan for the remainder of the twelve-month period.~~

~~A child may disenroll from a health or dental plan at least every 12 months at the time of renewal.~~
~~The Role of Federally Qualified Health Centers and Rural Health Centers~~
~~Effective July 1, 2013, the hawk-i program, through the participating health plans, will reimburse Federally Qualified Health Centers (FHQC) and Rural Health Centers (RHC) as follows:~~

~~UnitedHealthcare~~
~~UnitedHealthcare will contract with FQHCs and RHCs to reimburse FQHCs and RHCs at the most current Medicaid prospective payment system (PPS) to conform with the Benefits Improvements and Protections Act (BIPA) of 2000. There are no retroactive settlements required under the PPS.~~

~~Wellmark Health Plan of Iowa~~
~~Wellmark Health Plan of Iowa (WHPI) will reimburse FQHCs and RHCs using an Alternative Payment Methodology (APM). WHPI will pay FQHCs and RHCs on a fee for service basis. WHPI will analyze the payments on a quarterly basis, comparing them to the BIPA rate. If the FQHC/RHC was paid more than the Medicaid BIPA rate, no additional payments are made. If the analysis shows that what the FQHC/RHC's have been paid from WHPI fee schedule was less than what they would have received with the Medicaid BIPA rate, a supplemental payment issued through the state, for the difference, is paid to the FQHC/RHC. All supplemental payments will be reviewed by the department.~~

~~The FQHCs and RHCs have agreed to each plan's payment methodology. See Attachment~~

~~–~~The Role of Federally Qualified Health Centers and Rural Health Centers
Effective April 1, 2016, the hawk-i program, through the participating MCOs, will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) at 100 percent of the Medicaid Prospective Payment Systems (PPS).

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

MCO contracts require compliance~~UnitedHealthcare and Wellmark Health Plan of Iowa are managed care plans. Each plan is required in their contract to comply~~ with the relevant provisions of section 1932 of the Act and are submitted to CMS for review and approval.

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

~~MCOs and dental plans develop, operate and maintain a utilization management (UM) program. All UM strategies must be approved by DHS. MCO UM policies and procedures must meet all standards of the MCO's accrediting entity (i.e., NCQA or URAC) and shall have criteria that: (i) are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible; (ii) are applied based on individual needs; (iii) are applied based on an assessment of the local delivery system; (iv) involve appropriate practitioners in developing, adopting and reviewing them; and (v) are annually reviewed and up-dated as appropriate. Additionally, MCOs are required to establish practice guidelines that are based on valid and reliable clinical evidence or a consensus of healthcare professionals. MCOs must have in place and follow written policies and procedures, subject to DHS review and approval, for processing requests for initial and continuing authorizations of services and mechanisms to ensure consistent application of review criteria for prior authorization decisions.~~

~~Healthy And Well Kids in Iowa (hawk-i) Program~~

~~Health and dental plans are allowed to establish limits for services and implement utilization management guidelines such as requiring prior authorization and using drug formularies as long as the plan provides the required services and meets benchmark equivalency. Plans may not deny coverage due to the existence of a pre-existing medical condition.~~

~~The State conducts periodic evaluations of each health plan for the purpose of reviewing the policies and procedures for utilization management, appeals and grievances, contract compliance, health education programs and materials, and the quality improvement program.~~

~~Children who are determined presumptively eligible for hawk-i, will receive the Title XIX benefit package until such time as eligibility is confirmed or denied. Title XIX offers services to persons eligible for Medicaid through a fee-for-service delivery system. Medically necessary services are obtained by beneficiaries through contacted Medicaid providers. Children may obtain care from any contracted Medicaid provider of their choice.~~

~~When a formal eligibility determination of the presumptive eligibility application is complete, if eligible, the child will be enrolled for ongoing eligibility in the appropriate program, either Medicaid or hawk-i, based on established criteria.~~

MCOs and dental plans develop, operate and maintain a utilization management (UM) program. All UM strategies must be approved by DHS. MCO UM policies and procedures must meet all standards of the MCO's accrediting entity (i.e., NCQA or URAC) and shall have criteria that: (i) are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible; (ii) are applied based on individual needs; (iii) are applied based on an assessment of the local delivery system; (iv) involve appropriate practitioners in developing, adopting and reviewing them; and (v) are annually reviewed and up-dated as appropriate. Additionally, MCOs are required to establish practice guidelines that are based on valid and reliable clinical evidence or a consensus of healthcare professionals. MCOs must have in place and follow written policies and procedures, subject to DHS review and approval, for processing requests for initial and continuing authorizations of services and mechanisms to ensure consistent application of review criteria for prior authorization decisions.

The MCO's UM programs are not limited to traditional UM activities, such as prior authorization. The MCOs must maintain a UM program that integrates with other functional units as appropriate and supports the Quality Management and Improvement Program. The UM program must have policies and procedures and systems in place to assist UM staff to identify instances of over- and under-utilization of emergency room services and other health care services, identify aberrant provider practice patterns (especially related to emergency room, inpatient services and drug utilization), evaluate efficiency and appropriateness of service delivery, facilitate program management and long-term quality and identify critical quality of care issues. The MCO’s UM programs must link members to the MCO’s care coordination program.

The State conducts periodic evaluations of each MCO for the purpose of reviewing the policies and procedures for UM, appeals and grievances, contract compliance, health education programs and materials, and the quality improvement program.

Children who are determined presumptively eligible (PE) for hawk-i, will receive the Title XIX benefit package until such time as eligibility is confirmed or denied. Title XIX offers services to persons eligible for Medicaid through a fee-for-service delivery system. Medically necessary services are obtained by beneficiaries through contracted Medicaid providers. Children may obtain care form any contracted Medicaid provider of their choice.

~~MCOs and dental plans develop, operate and maintain a utilization management (UM) program. All UM strategies must be approved by DHS. MCO UM policies and procedures must meet all standards of the MCO's accrediting entity (i.e., NCQA or URAC) and shall have criteria that: (i) are objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible; (ii) are applied based on individual needs; (iii) are applied based on an assessment of the local delivery system; (iv) involve appropriate practitioners in developing, adopting and reviewing them; and (v) are annually reviewed and updated as appropriate. Additionally, MCOs are required to establish practice guidelines that are based on valid and reliable clinical evidence or a consensus of healthcare professionals. MCOs must have in place and follow written policies and procedures, subject to DHS review and approval, for processing requests for initial and continuing authorizations of services and mechanisms to ensure consistent application of review criteria for prior authorization decisions.~~

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☐ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
The State has opted to use the SSA verification option.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:
Children up to age 19 are covered. Coverage ends effective the first day of the month following the month of the nineteenth birthday.

4.1.2.1-PC ☐ Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☒ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through % of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):
There is no minimum period of time in which the child must reside in the State to establish ~~resdiency~~residency. A resident is one:
a. Who is living in Iowa voluntarily with the intention of making that person's home in Iowa and not for a temporary purpose; or
b. Who, at the time of application, is not receiving assistance from another state and entered Iowa with a job commitment or to seek employment or who is living with parents or guardians who entered Iowa with a job commitment or to seek employment.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 ☒ Access to or coverage under other health coverage:

A child who is covered under other health insurance is not eligible for coverage under hawk-i unless the coverage is a single service coverage such as a dental only or vision only policy. Access to coverage is not considered if the child is not actually covered.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

The eligibility period is 12 months.

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Inmates of nonmedical public institution. At the time of application or annual review of ~~eligiblity~~eligibility, the child shall not be an inmate of a nonmedical public institution as define at 42 CFR Section 435.1009 as amended November 10,1994.

Inmates of institutions for mental disease. At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

Social Security Numbers are required only for children who are applying for the hawk-i program. Social Security Numbers are optional for those not applying to the program.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number

system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age 19

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☒ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

~~Initial Enrollment~~

~~Applications for the hawk-i program are received via mail, fax, or on-line through the hawk-i web site by the third party administrator at a central location in Des Moines, Iowa.~~

~~Applications are screened for completeness of information, the presence of other health insurance, verification of income, the presence of State of Iowa employment, and Medicaid eligibility. If it appears that a child is Medicaid eligible, the application is referred to a Medicaid eligibility worker co-located at the third party administrator's office for a Medicaid eligibility determination.~~

~~Upon receipt of a completed application, the third party administrator must determine hawk-i eligibility within 10 working days. If it is determined the child is uninsured, that countable income does not exceed the hawk-i limit, and that the child otherwise qualifies, a notice of approval is sent to the family. Included with the approval notice is information about the health and dental plans available to the family and a Plan Selection form on which the family must make their selection. If countable income exceeds 150% of FPL but does not exceed 200 % of FPL, the family is also required to pay a premium of $10~~

per month per child, not to exceed $20 per month, regardless of family size. If countable income exceeds 200% of FPL but does not exceed 300% of FPL, the family is required to pay a premium of $20 per month per child, not to exceed $40 per month, regardless of family size. Cost sharing is not assessed to American Indian or Alaska Native children, regardless of income.

Upon approval of an initial application, the first month for which a premium will be due is the third month following the month in which the approval letter was sent to the applicant. The first premium shall be due on the 10th calendar day of the second month following the month in which the approval letter was sent to the applicant. Note: An "initial application" is an application that is not an annual renewal.

For the months of June 2008 and July 2008, the premiums for families with countable income that equals or exceeds 150% of FPL are waived. The basis for this waiver is good cause due to the financial hardship for those families with limited income in any of the Iowa counties that have been declared a disaster by the Governor of Iowa and/or Presidential Declaration of Disaster for Individual Assistance.

Upon receipt of the Plan Selection form, the third party administrator notifies the health plan of the new enrollment. If the Plan Selection form is not returned by the due date, the third party administrator randomly assigns the family to a health plan. The family has thirty days to notify the third party administrator if they want to change the health plan. The health plan provides an identification card, an explanation of coverage, and a list of participating providers to the family.

Ongoing Eligibility During the 12-Month Enrollment

Once eligibility is established, the child shall remain enrolled in the hawk-i program for a 12-month enrollment period unless one of the following occurs:

a. The child moves to an area of the state not served by that plan. In which case, the child shall be enrolled in a participating plan in the new location. The enrollment period is the remaining months of the original 12-month enrollment.

b. Age. The child shall be disenrolled from the hawk-i program as of the first day of the month following the month of the nineteenth birthday.

c. Nonpayment of premiums. The child shall be disenrolled as of the first day of the month following the month in which premiums are not paid. If the family reports a decrease in income during the 12-month enrollment period, premium cost sharing is re-evaluated. If the family's income is reduced below 150 percent of FPL, the family will not have to pay a premium for the remaining months of the enrollment period.

d. Iowa residence is abandoned. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which the child relocated to another state.

e. Medicaid eligibility. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which Medicaid eligibility is attained.

f. Enrolled in other health insurance. The child shall be disenrolled from the plan as of the first day of the month following the month in which the child attains other health insurance coverage.

g. Admission to a nonmedical public institution. The child shall be disenrolled from the plan and canceled from the program as of the first day of the month in which the child enters a nonmedical public institution unless it can be established that the absence is temporary.

h. Employment with the State of Iowa. The child shall be disenrolled from the plan and canceled from the hawk-i program as of the first day of the month in which the child's parent becomes eligible to

~~participate in a health plan available to State of Iowa employees.~~

~~Recertification~~
~~All eligibility factors are reviewed annually as follows:~~
~~a. Sixty (60) days prior to the end of the 12-month enrollment period, the third party administrator mail a hawk-i renewal application form to the family. The renewal application form is preprinted with the information known about the household. The family is asked to verify the correctness of the information and return the corrected form with current income verification. A postage-paid return envelope is provided.~~
~~b. If the family fails to return the information or required income verification, the child shall not be recertified for the next 12-month enrollment period.~~
~~c. Upon a determination that the child continues to meet all eligibility factors, the family shall be allowed to select another plan for the next 12-month enrollment period if another plan is available. If the family does not select another plan, the child shall be re-enrolled with the current plan for the next 12-month enrollment period.~~

With the implementation of the ACA, all applications are processed through an integrated eligibility system. All applications are first determined for Medicaid eligibility and then if not Medicaid eligible, the application is then determined for hawk-i eligibility.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

☒ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☒ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Presumptive Eligibility

Staff of qualified entities selected and trained by the Medicaid state agency are authorized to determine presumptive eligibility. The eligibility income standard is income at or below 300% FPL. All presumptive eligibility applications are electronically referred to the Iowa Department of Human Services for an ongoing Medicaid or hawk-i eligibility determination. Medicaid eligibility is determined first. If the child is not eligible for

Medicaid, the application is referred for a hawk-i eligibility determination.

Presumptive eligibility begins on the day the qualified entity determines that the child appears eligible and ends when one of the following occurs:

- the last day of the next calendar month after the month of application, OR
- the day ongoing Medicaid is established, OR
- the day the hawk-i eligibility decision is made, OR
- the last day of next calendar month, after the month of application, if the Medicaid application is withdrawn.

Children who are determined presumptively eligible for hawk-i will receive the Title XIX benefit package until such time as eligibility is confirmed or denied. Title XIX offers services to persons eligible for Medicaid through a fee for service delivery system. Medically necessary services are obtained by beneficiaries through contracted Medicaid providers. Children may obtain care from any Contracted Medicaid provider of their choice.

Each child is eligible for only one period of presumptive eligibility within a twelve (12) month period. The 12-month period begins on the first day of presumptive eligibility determination.

When a formal eligibility determination of the presumptive eligibility application is complete, if eligible, the child will be enrolled for ongoing eligibility in the appropriate program, either Medicaid or hawk-i, based on established criteria.

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☒ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

Express Lane option for hawk-i applies to initial and renewal ~~eligiblity~~eligibility determinations.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

For Medicaid. The express lane eligibility agency for Medicaid is Supplemental ~~Nutrtion~~Nutrition Assistance Program (SNAP). The child's household income as

calculated by SNAP is used to determine eligibility for Medicaid. A Medicaid application is not required. The household must request medical assistance and return a signed form to the Medicaid office.

For hawk-i. The express lane ~~eligiblity~~eligibility for the hawk-i program is Iowa Medicaid.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.
When a child is determined ineligible for Medicaid because they are over income at initial application, the Medicaid eligibility system automatically takes the ~~eligibilty~~eligibility work to a screen on ~~whlich~~which to make an ~~elctronic~~electronic referral to the State's separate CHIP program. The notice of decision informing the family that the child is not eligible for Medicaid also informs the family that eligibility under the separate CHIP program is being examined.

Demographic data ~~regrading~~regarding the family and household income is ~~electrnoically~~electronically transferred to the Third Party Administrator's (TPA) proprietary ~~systme~~system for a determination of eligibility for the separate CHIP program. Demographic data includes whether citizenship and identity has been verified, the child's insured status, household composition, birthdates, social security numbers, etc. The income calculation used to determine Medicaid ~~ineligiblilty~~ineligibility is accepted by the TPA to ~~etablish~~establish whether the child is under the income limits of the separate CHIP program. If the child is uninsured, citizenship and identity have been verified, and family income is under CHIP income limits, the child is enrolled in the program. If the child's citizenship and identity were not previously verified and a 90-day reasonable opportunity ~~peirod~~period has not been provided, the child is enrolled in the program and a 90-day period in which to verify ~~stateus~~status is provided.

If a child on Medicaid is found to be over income for Medicaid at the time of renewal, a referral to the separate CHIP program is made as described above.

If the Medicaid referral indicates the child is insured and/or that a reasonable opportunity period to verify citizenship and identity has been provided but verification has not been received, the application is denied.
4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.
See above.
4.3.3.4-EL Describe the option used to satisfy the screen and enrollment

requirements before a child may be enrolled under title XXI.

A Medicaid screen and enroll function is not performed by the TPA as part of the referral ~~proces~~process because the referral come from the Medicaid agency and ineligibility has already been established. The Medicaid screen and enroll process is completed when the family applies for the separate CHIP program first.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.
Refer to response in 4.3

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))
Refer to response in 4.3

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR

431.636(b)(4))
Refer to response in 4.3

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

American Indian and Alaska Native Children are eligible for hawk-i program on the same basis as any other children in the State, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care. No premiums or other cost sharing apply to American Indian or Alaska Native children.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☒ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Medicaid

The Medicaid program is the only public health insurance program for children in Iowa. Medicaid is administered through the Department of Human Services (DHS) Central Office in Des Moines and through 104 DHS offices (including the Refugee Services Center) located in all 99 counties. Additionally, outstationed eligibility workers are currently located at Broadlawns Hospital in Des Moines. The University of Iowa in Iowa City has 6 intake positions.

There are five Federally Qualified Health Centers (FQHC) in Iowa. Currently there is one outstationed eligibility worker position at each of these sites.

Medicaid applications are readily available to anyone who requests one. Additionally, there is a toll-free number for anyone to call and ask questions about Medicaid eligibility and to find how to apply. The number is 1-800-869-6334.

In April 2000, Iowa had 129,192 children with health care coverage through the Medicaid program. Eligibility for Medicaid continues to remain available for the following federal categories of children. Those who qualify because they would have been eligible for cash assistance prior to July 16, 1996, and related categorical programs; those who are in foster care and subsidized adoption; those who qualify for the Mothers and Children program (SOBRA); those who meet disability criteria; those who are medically needy, and those who qualify under the following home and community based waivers:

Enrollment Cap	
Ill and Handicapped Waiver	1660
Mental Retardation Waiver	2348(for children) + 100 ICF/MR beds
Brain Injury Waiver	372
AIDS Waiver	50
Physical Disability Waiver	144

Elderly Waiver Dependent on number of clients enrolled and amount of reimbursement for clients

Health Insurance Premium Payment Program (HIPP)
Iowa was one of the first states to implement the provisions of section 1906 of the Social Security Act which mandated states to purchase employer-related health insurance coverage for Medicaid-eligible persons when it was determined cost-effective to do so. Iowa implemented the Health Insurance Premium Payment (HIPP) program on July 1, 1991. Although section 1906 of the Social Security Act has now become optional, Iowa continues to maintain a strong HIPP program. Although this program is primarily designed to reduce Medicaid expenditures by providing a third party resource for Medicaid-eligible persons, oftentimes it is cost-effective to purchase family coverage which results in providing coverage for the non-Medicaid eligible household members as well. By initiating coverage while on Medicaid, families have coverage in place when they leave the Medicaid roles.

Direct Health Services (Title V, Title X, WIC, etc.)
The Iowa Department of Public Health (IDPH) is the largest single provider of direct as well as support patient care for uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (EPSDT) and well-child check-ups, prenatal services, Women, Infants and Children Supplemental Nutrition (WIC) program services, preventive health education, immunizations, and family planning services. Support services include case coordination services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family programming funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue collected on a sliding fee scale by Title V agencies. A variety of the above direct and support services are provided within each of the 99 Iowa counties. Twenty-six Maternal Health Centers and twenty Child Health Centers provide statewide services. Adolescent services are provided in 25 locations in the state.

Additionally, there are approximately 486 full-time school health nurses working under the auspices of the Iowa Department of Education and local education agencies in the state who provide a variety of health screening services, care coordination and emergency services.

Income assessments are performed on patients enrolled in IDPH clinics. The income assessments are reviewed for possible Medicaid eligibility. New applications, as well as annual reviews of established patients, are assessed by IDPH intake staff and/or care coordinators for possible referral for medical assistance through Medicaid and/or SSI.

In order to provide additional outreach, The IDPH operates two toll-free telephone lines for use by the general public. The toll-free telephone lines are known as Healthy Families and Teen Line. These are information and referral services for health issues. The Healthy Families line addresses a wide variety of health issues with emphasis on prenatal care. The Teen Line also addresses a variety of issues specifically related to the health of teenagers. Topics covered include drugs, sexual relationships, eating disorders, relationships with parents, and violence. Two integral parts of the information provided to callers, via these telephone lines, are information on Medicaid eligibility and referrals to community

based care coordinators who can assist clients with locating local health providers who accept Medicaid-eligible children and Medicaid-eligible pregnant women. The toll-free number for Health Families is 1-800-369-2229. The Teen Line number is 1-800-443-8336. Both lines are operational 24 hours a day, seven (7) days a week.

Child Health Specialty Clinics
Each year, approximately 5,500 Iowa children receive services at the Child Health Specialty Clinics (CHSC). The Department of Human Services has an interagency cooperation agreement with the CHSC which serve as a link between major medical centers and the community by assisting families to obtain needed resources. The CHSC serves children from birth to 22 years with or at risk of a chronic health condition or disability, which includes psychosocial, physical, health-related educational and behavioral needs. The specific health concerns may be simple or complex, short-term or long-term.

Small Group Insurance Reform
Iowa enacted small group reforms in 1992. These reforms provided more affordable coverage for the small group market, thus allowing employees and their dependents to obtain coverage at more affordable rates. The reforms included limitations on rate increases as well as limitations on pre-existing condition clauses.

In 1996, Iowa implemented individual market reforms which provide for portability for employees and their dependents form a group to the individual market, as well as rating restrictions on individual products.

State High Risk Insurance Pool
Iowa law established a state administered high-risk health insurance program for those individuals and their dependents who cannot obtain coverage in the private market. This program is funded by a 2% tax on health insurance premiums. Persons who are eligible for Medicaid or COBRA continuation coverage are not eligible to participate in this program. Coverage in the high-risk program provides for individuals to the private market.

Express Lane Eligibility
The State elects the Express Lane Eligibility option to rely on a finding of ineligibility from the Medicaid agency to determine eligibility for the separate CHIP program.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Currently there are no health insurance programs that involve a public-private relationship.

The Caring Program for Children

There was one health insurance program in Iowa that resembled a public-private partnership. However, it was not administered by the State. This program was known as the Caring Program for Children and was administered by Wellmark (Blue Cross and Blue Shield of Iowa and South Dakota). The Iowa Caring Foundation provided ambulatory health insurance to low income, non-Medicaid/uninsured children under the age of 19 years who remain full-time students through grade 12. During its 10 years of operation, the Caring Foundation was funded through a state appropriation and private donations, with matching funds from Wellmark. At its peak the Caring Program had an enrollment of over 3000 children. The Caring Program ceased operation on June 30, 1999.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

At the time a child is determined not to be eligible for hawk-i, the letter the applicant receives states: "XXX is not approved for MAGI benefits. We have referred your application to the Federal Marketplace. They may contact you for eligibility to Qualified Health Plan."

When it is determined that a child does not qualify or will no longer qualify for Medicaid due to excess income, a referral is made to hawk-i within the eligibility system.

If an individual applying for health services through a public health clinic also wishes to apply for Medicaid or hawk-i, the public health clinic will forward this information to Medicaid within two working days. If an individual applying for WIC services also wishes to apply for Medicaid, the WIC agency will forward the information to Medicaid.

The Iowa Department of Human Services has a contract with the Iowa Department of Public Health to conduct grassroots outreach activities for the hawk-i and Medicaid programs. The Iowa Department of Public Health who oversees the Title V agency, will ask the Title V agencies to either conduct the grassroots outreach activities or to subcontract with an agency or organization to do outreach. The Title V agencies are responsible for doing a gap analysis to see what community agencies are currently doing for outreach as well as determine what is missing. The action plan must include how outreach to identify children who are eligible for Medicaid or hawk-i and advise them where and how to enroll and how to

maintain enrollment. ~~Although you child does not qualify for hawk-i, health care services may be available through your local child health agency. For information about the child health center in your area, please call 1-800-369-2229 (Iowa Healthy Families Information and Referral Service)."~~

~~When it is determined that a child does not qualify or will no longer qualify for Medicaid due to excess income, a referral is made to hawk-i. The referral can be accomplished either electronically or using a paper form. In either format, the referral includes the name of the child (or children), the Medicaid application date (for children denied Medicaid) or the Medicaid end date (for children cancelled from Medicaid), and the reason for the referral. The electronic referral also includes the income amounts used to determine Medicaid ineligibility. A copy of the Medicaid notice of decision denying or cancelling Medicaid accompanies the paper referral. This notice contains a calculation showing how Medicaid ineligibility due to excess income was determined.~~

~~The third party administrator performs a comparison of hawk-i enrollees to Medicaid enrollees. A file containing the Medicaid enrollees is received and matched daily with the hawk-i enrollee file. If a match is found, the child is cancelled from hawk-i after being given notice of the cancellation.~~

~~If an individual applying for health services through a public health clinic also wishes to apply for Medicaid or hawk-i, the public health clinic will forward this information to hawk-i within two working days.~~

~~If an individual applying for WIC services also wishes to apply for Medicaid, the WIC agency will forward the information to Medicaid. If an individual applying for WIC appears to qualify for hawk-i, the individual is given a hawk-i enrollment form.~~

~~If a child applying for hawk-i is determined to be eligible for Medicaid, a referral for EPSDT is made. If a child or family asks about WIC, a WIC brochure along with the location of the nearest WIC is given to them.~~

~~In the action plans of the Title V agencies in Iowa, the Title V agencies have included outreach to hawk-i and Medicaid to children who may be eligible. The agencies will identify these children, notify the families of the program and advise them where and how to enroll and how to maintain the enrollment.~~

~~The Iowa Department of Human Services will be entering into a contract with the Iowa Department of Public Health to conduct grassroots outreach for the hawk-i and Medicaid programs. The Iowa Department of Public Health who oversees the Title V agencies, will ask the Title V agencies to either conduct the grassroots outreach activities or to subcontract with an agency or organization to do outreach. The Title V agencies will be responsible for doing a gap analysis to see what community agencies are currently doing for outreach as well as determine what is missing. The action plans must include the results of the gap analysis and what steps the agency will take to involve the community in conducting outreach.~~

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment

of eligible children into Medicaid or CHIP.

The State elects the Express Lane eligibility option to rely on a finding of ~~ineligiblity~~ineligibility from the Medicaid agency to determine eligibility for the separate CHIP program. The outreach coordinators in the local communities are taught that if a Medicaid application or renewal is over-income for Medicaid, an automated referral is made to hawk-i.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Historical Outreach

Grassroots Outreach

In July of 1999, the hawk-i Board directed the Iowa Department of Human Services to develop a grassroots outreach effort. The Department developed a plan by which communities would bring together those individuals and entities that touch the lives of families with children in order to develop a community outreach strategy. Once the plan was developed, it was submitted to the Department for approval and funding was made available to assist in the implementation plan. Currently, the Department has 53 community outreach contracts that cover 89 counties.

Covering Kids Grant Project:

Covering Kids is a 3-year grant that was awarded to the Iowa Department of Public Health in 1999 by the Robert Wood Johnson Foundation. The purpose of the grant is to increase access to health care coverage for all uninsured and underinsured children in Iowa. Administrators of the grant work collaboratively with the Iowa Department of Human Services, the Iowa Department of Education, advocates, medical providers, and others to address barriers to access for uninsured and underinsured children. This grant expires on June 30, 2002. As of July 1, 2002, the Iowa Department of Public Health will continue this work under a new 4-year Robert Wood Johnson Covering Kids and Families grant.

Mass Media Campaign

During the spring of 2001, a short-term mass media campaign was used. Television commercials that had been produced for the national Insure Kids Now effort were used. Commercials were aired in both

English and Spanish. Also a 60-second radio commercial in English and Spanish was produced. The commercials were aired for a seven-week period during March, April and May. There was an immediate response to the media campaign. During the six-month period prior to the campaign, the hawk-i customer service center received an average of 400 application requests per month. During the three months in which the commercials aired, application requests averaged 1,500 per month.

Other Media

Ads have been placed in the Qwest Dex directory, in the yellow pages as well as the internet listing hawk-i 's toll free number. Ads have also occurred in various local and state newsletters, magazines, and other publications.

Partnering with Schools

The Department of Human Services and the Department of Education collaborated to develop an interagency agreement that allowed schools and child care providers who participate in the Free and Reduced Meals Program to make referrals to the hawk-i Program for outreach purposes. Under this initiative, the names of applicants for the Free and Reduced Meals Program are referred to the hawk-i Program unless the family specifically asks not to be referred. Participating schools submitted a list of names to the hawk-i customer service center and then the customer service center mailed an application and information to the families. During the first year of this effort, applications were mailed to approximately 6,000 families. The Departments are working together to ensure this will be an ongoing effort.

Literacy Project

Iowa was one of seven states selected to participate in a literacy project being conducted by the Centers for Medicare and Medicaid Services. The purpose of the project was to evaluate applications, brochures and other state-produced materials to assess how they could be modified to ensure comprehension by persons with very low literacy levels. Additionally, materials written in non-English languages were evaluated to see if they would meet the needs of the populations for which they were intended. These findings are being utilized in the study to redesign the hawk-i application and brochure in order to remove as many barriers to enrollment as possible.

Multi-Language Poster

The Department of Human Services introduced a new multi-language hawk-i poster in October 2001 in order to ensure that the needs of persons with limited English proficiency were being met. The poster provides information about the program in five languages: English, Spanish, Bosnian, Vietnamese, and Laotian. It also informs that translator services are available to assist them applications. The need for translation of information into these specific languages was identified through input of local outreach workers, the Bureau of Refugee Services, and use of AT&T translator lines by the hawk-i customer service center.

Corporate Involvement

Nationally, there has been a growing interest by large corporations to assist states in promoting their SCHIP Program. Iowa actively takes advantage of these efforts to further promote the program. Some of these efforts in Iowa included:

☐ Wal-Mart/Pampers
☐ H&R Block
☐ The Marmaxx

In addition to the outreach activities aimed at enrolling eligible children, the state agencies' existing efforts to promote the use of health care services and continuity of care will also be expanded to include the new Title XXI enrollees. These activities include use of the media, case management, and patient follow-up systems, (especially within the Title V, Title X and Title XX Block Grant Programs, and related programs for children within the Iowa Department of Human Services).

Case management consists of a variety of activities designed to identify an individual patient's psychosocial needs and barriers to obtaining health services (such as enrolling in Medicaid), and assist the patient in meeting those needs and accessing services. Patient follow-up includes a variety of activities designed to ensure that patients comply with the recommendations of their health care provider(s) and continue in the health system.

One example of Iowa's continuing effort to improve the health status of school-aged children, the Project Success Program, coordinates social and health services with parental involvement in 13 designated school sites in the Des Moines school district. Project Success sites, which include seven elementary schools, two middle schools, two high schools, and two alternative high schools, refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen schools based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.
Outreach Activities from 2006 to present:
Media Campaign: In September 2007, the DHS entered into a contract with ZLRIGNITION (ZLR), a media buyer, to develop a media campaign for the hawk-i and Medicaid program. ZLR conducted focus awareness groups of the hawk-i program. Based on the results of the focus groups, ZLR developed television, radio and print ads that focused on working families who do not have health insurance for their children. See Attachment 15 for results.

Income Tax Match: In September 2008, DHS began working with the Iowa Department of Revenue to add a question to the Iowa 2008 tax forms for families about health care coverage for their children. Families who answered the question with no my children do not have health care coverage and who's income was within the federal poverty were sent a hawk-i application by the Department of Revenue. This process will be further refined for the 2009 tax season. See Attachment 15 for results.

Outreach in local communities: In July 2006, DHS entered into contract with the Iowa Department of Public Health (IDPH) to conduct outreach in local communities. IDPH subcontracts with their Title V agencies for outreach activities. Such activities include, but are not limited to: health fair presentations, contacting local church and business and back to school registrations.

Free and Reduced Meals: In the 2007 Iowa legislative session, schools are mandated to provide names of children who participate in the free and reduced meal program as listed above in "Partnering with Schools". Each year the process is further refined to make this process easier. DHS has also expanded

this effort to include day care and preschools in addition to schools.

Current strategies as of July 2015:
The Department continues to contract with the Iowa Department of Public Health to conduct outreach at a grassroots community level. There is also a state wide outreach coordinator associated with the contract. This person is responsible for conducting outreach activities on a state wide basis and overseeing the Title V agencies outreach plans.

The Free and Reduced Meals continues with schools providing names of those children who participate in the free and reduced meals program.

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the

plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. **(**Section 2103(a)(2))

6.1.2. ☒ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.
See Attachment 3 for the benchmark plan.

~~Effective October 1, 2009, UnitedHealthcare Plan of the River Valley (See Attachment 4) and Wellmark Health Plan of Iowa (See Attachment 12) are the health plans participating in the hawk-i program. Delta Dental of Iowa is the dental plan (See Attachment 11).~~

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☐ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☒ Coverage the same as Medicaid State plan
This coverage is only available to those found to be presumptively eligible for hawk-i. Services covered in Title XIX that are not covered in the separate CHIP program under XXI (hawk-i) are subject to the administrative expenditures under Title XXI.

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including

residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☐ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☒ Nursing care services (Section 2110(a)(15))

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.20. ☒ Case management services (Section 2110(a)(20))

6.2.21. ☐ Care coordination services (Section 2110(a)(21))

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.23. ☒ Hospice care (Section 2110(a)(23))

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☐ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)

3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

See Attachment 16 for the Iowa hawk-i Dental Plan.

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- ☐ State-developed Medicaid-specific
- ☒ American Academy of Pediatric Dentistry
- ☐ Other Nationally recognized periodicity schedule
- ☐ Other (description attached)

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☒ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section

2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4. **Additional Purchase Options-** If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount

of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☐ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☐ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health

assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

~~The Department of Human Services encourages all contracted managed health plans to pursue National Committee for Quality Assurance (NCQA) or Joint Commission on Accreditation of Health Care Organizations (JCAHO) certification~~

The Department of Human Services requires MCOs to attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC. If not already accredited, MCOs must demonstrate initiation of the accreditation process as of the effective date of contracting with the State. MCOs must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract with the State.~~.~~

The Department of Human Services requires MCOs to attain and maintain accreditation from the National Committee for Quality Assurance (NCQA) or URAC. If not already accredited, MCOs must demonstrate initiation of the accreditation process as of the effective date of contracting. MCOs must achieve accreditation at the earliest date allowed by NCQA or URAC. Accreditation must be maintained throughout the life of the MCO's contract with the State.

7.1.2. ☒ Performance measurement

Refer to Section 9.1

7.1.2 (a) ☒ CHIPRA Quality Core Set

The ~~managed care plans~~MCOs are responsible for following the CHIPRA quality core set for well-child, well-adolescent and immunizations.

7.1.2 (b) ☒ Other

–MCOs produce contractually required HEDIS measures following HEDIS specifications on an annual basis. Data is used to monitor quality of care. DHS utilizes the data obtained in setting quality strategy goals, performance standards, improvement plans and incentive payments.

7.1.3. ☒ Information strategies

MCOs are required to provide encounter data in accordance with the provisions outlined in their contract. Encounter data is used to monitor service utilization and quality. Additionally, MCOs are required to provide written information to enrollees regarding availability of services, which, at a minimum includes the following: (i) a provider director and/or information on how to find a network provider near the member's residence; (ii) MCO contact information; (iii) the amount, duration and scope of services available; (iv) hours of operation, including the availability of the member helpline and 24-hour nurse call line; (v) procedures for obtaining benefits; (vi) descriptions of any restrictions on the member's freedom of choice among network providers; (vii) how to complete a risk screening; (viii) grievance and appeals information; (ix) after-hours, emergency coverage and post-stabilization care services information; (x) cost-sharing information; (xi) member protections, rights and responsibilities; (xii) procedures for obtaining out-of-network services; (xiii) standards and expectations for receiving preventive health services; (xiv) procedures for making complaints and recommending changes in policies and services; (xv) information about advance directives; (xvi) availability of alternative methods or formats of communication; and (xvii) information and procedures on how to report suspected abuse and neglect. ~~All health plans participating in the hawk-i program are required to provide encounter data in accordance with the provisions outlined in their contract.~~

~~Additionally, all health plans are required to provide written information to enrollees which, at a minimum includes the following:~~

~~the phone number(s) that can be for assistance to obtrain information about emergency care, prior authorization, scheduling appointments, and standard benefit/services information;~~

~~current provider directory;~~

~~hours of service of the plan;~~

~~appeal procedures;~~

~~policies on the use of emergency services;~~

~~information on the use of non-participating providers;~~

~~access of after-hours care;~~

~~enrollee rights and responsibilites~~

~~procedures for notifying enrollees of changes in benefits or delivery of services: and procedures for recommending changes in policies and procedures.~~

7.1.4. ☒ Quality improvement strategies

MCOs are required to develop a work plan for the Quality Management and Improvement Program, which includes performance improvement projects, to identify the goals the MCO has set to address its strategy for improving the delivery of health care benefits and services to its members. The work plan identifies the steps to be taken and includes a timeline with target dates. The plan is submitted prospectively for each year, with quarterly updates and a final evaluation of the prior year.

The Clinical Advisory Committee meets quarterly to review data, reports and medical audit results. The committee makes recommendations to the hawk-i Board on program quality standards and improvement strategies. The seven-member committee is comprised of community medical professionals, representing pediatricians, family practice, nurse practitioners and mental health.
~~All health plans participating in the hawk-i program are required to have quality improvement plans in place, including mechanisms that allow enrollees to provide input as to how the delivery of services and other aspectes of the plan could be improved.~~

~~The Clinical Advisory Committee meets quarterly to review data, reports and medical audit results. The committee makes recommendations to the hawk-i Board on program quality standards and improvement strategies. The seven-member committee is comprised of community medical professionals, representing pediatricians, family practice, nurse practitioners and mental health.~~

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

All ~~health plans~~MCOs are contractually required to provide well-baby care and well-child care, well-adolescent care and childhood and adolescent immunization services.
All participating ~~health plans~~MCOs develop programs to enhance the general health and well-being of members including educational strategies regarding the importance of preventive care including immunizations and age appropriate recommended screenings. ~~send reminder notices to families that their child(ren) is due for immunizations or well-child visits. Additionally, newsletters are sent to families educating them about the importance of preventative services.~~

The hawk-i Program collects encounter claims data from participating health and dental plans monthly. HEDIS performance measurements for well-child and adolescent care have been

selected for results based analysis (see 9.1). Effective AprilJuly 1, 2016005, the Department has a contract with an EQRO TelligenIowa Foundation for Medical Care to validate the encounter claims data. with a medical record review.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

DHS examines access to care through the annual external quality review Telligen (formerly IFMC) contract. Additionally, MCOs must submit monthly geo-access maps to allow the State to monitor access to covered services. This data is analyzed on a monthly basis by DHS to assess MCO capacity to service members and access to care within reasonable travel times based on the members' residential zip code to the providers' office/facility location zip code. The MCOs are contractually required to meet the following access standards: (i) primary care physician access within 30 minutes/30 miles; (ii) specialty care access within 60 miles/60 minutes for 75% of the membership and 90 miles/90 minutes for all members; (iii) behavioral health access within 30 minutes/30 miles; and (iv) transport time to hospitals shall be the usual and customary not to exceed 30 minutes/30 miles unless community standards apply. Additionally, MCOs are required to cover emergency care at the nearest facility available, regardless of whether the facility or provider is a network provider. Additionally, DHS uses Geographic Information Systems (GIS) maps to examine the distribution of primary care, dental, and mental health providers for each participating health plan at the county level of geography. The map tracks the geographical distribution of providers in comparison to the number of beneficiaries served in a particular coverage area as well as the distance and time to get to the provider. Access standards utilized for the GIS are 30 minutes/30 miles for primary care provider and dental services, 60 minutes/60 miles for specialty services including mental health and substance abuse.

As noted above, health plansMCOs are contractually required to include written procedures in the member enrollment materials handbook on accessing services, including emergency services.

Contracted MCOs are required to submit monthly grievance and appeals data and dental plans health and dental plans are required to submit such reports complaint/grievance reports to the Department on a quarterly basis. Additionally, MCOs conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys which assess enrollees experience with their health care and access to services. assessment surveys ask specific questions about the member's satisfaction with emergency services.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Contracted MCOs are required to meet specialty access standards as described above. MCOs are contractually required to contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of members are met within the MCO's provider network. MCOs must also have a system to refer members to, and pay for, non-network

providers when medically necessary and must pay for non-network providers when a member has medical needs that would be adversely affected by a change in service providers. All non-network providers referred to and reimbursed must have the necessary qualifications or certifications to provide the medically necessary service. At minimum, MCOs must have provider agreements with providers practicing the following specialties: (i) allergy; (ii) cardiology; (iii) dermatology; (iv) endocrinology; (v) gastroenterology; (vi) general surgery; (vii) neonatology; (viii) nephrology; (ix) neurology; (x) neurosurgery; (xi) obstetrics and gynecology; (xii) occupational therapy; (xiii) oncology/hematology; (xiv) ophthalmology; (xv) orthopedics; (xvi) otolaryngology; (xvii) pathology; (xviii) physical therapy; (xix) pulmonology; (xx) psychiatry; (xxi) radiology; (xxii) reconstructive surgery; (xxiii) rheumatology; (xxiv) speech therapy; (xxv) urology; and (xxvi) pediatric specialties. MCOs must analyze the clinical needs of the enrolled membership to identify additional specialty provider types to enroll.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

MCOs must notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed seven (7) calendar days after the request for services. An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the MCO justifies to DHS a need for more information and explains how the extension is in the member's best interest.

~~The following language is included in all health plan contracts follows: "If the Plan has Prior Authorization of health services, in accordance with the medical needs of the patient, the Plan shall complete the Prior authorization within fourteen (14) days after receipt of a request for services. An extension of up to fourteen (14) days may be permitted if the Enrollee requests the extension or if the physician or Plan determines that additional information is needed."~~

Expedited Timeframes

In situations where a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) days after receipt of the request for service. The MCO may extend the three (3) days by up to fourteen (14) calendar days if the member or the provider requests an extension or the MCO justifies a need (to the State agency, upon request) for additional information and how the extension is in the best interest of the member. The MCO shall be required to provide its justification to the Agency upon request. Unless otherwise provided by law, if

the MCO fails to respond to a member's prior authorization request within three (3) days of receiving all necessary documentation, the authorization is deemed to be granted and notice shall be given. In accordance with 42 C.F.R. § 438.404(c)(1), if MCO intends to take an action to terminate, suspend, or reduce previously authorized Medicaid-covered services, MCO shall give notice of the adverse action at least 10 days before the date of action.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☒ Premiums:

For enrollees with countable income exceeding 200 percent but not exceeding 300 percent of the FPL, premiums will be $20 per month per child with a monthly family maximum of $40. For enrollees with countable income equal to or exceeding 150 percent but not exceeding 200 percent of FPL, premiums will be $10 per month per child, with a monthly family maximum of $20.
For enrollees with countable earned and unearned income less than 150% of the FPL, no premium is assessed.

Effective July 1, 2014; the new MAGI converted federal poverty levels changed. For enrollees with income that is above 167 percent of the FPL and up to 181 percent of the FPL, there is no premium. For enrollees whose MAGI income is at or above 182 percent of the FPL and up to 243 percent of the FPL, a premium of $10 per child per month with a monthly family maximum of $20 is assessed. For enrollees whose MAGI is at or above 244 percent of the FPL and up to and including 302 percent of the FPL,

premiums are $20 per child per month with a monthly family maximum of $40.

No cost-sharing is assessed for eligible Native American / Alaskan Native children regardless of family income.
If a family reports a decrease in income anytime during the 12-month eligibility period and the new income is less than 181 percent of the FPL, the family does not pay a premium for the reminder of the eligibility period.
For the months of June 2008 and July 2008, the premiums for families with countable income that equals or exceeds 150% of FPL are waived. The basis for this waiver is good cause due to the financial hardship for those families with limited income in any of the Iowa counties that have been declared a disaster by the Governor of Iowa and/or Presidential Declaration of Disaster for Individual Assistance. See Attachment 14 for the list of Iowa counties affected as of June 30, 2008

8.2.2. ☐ Deductibles:

8.2.3. ☒ Coinsurance or copayments:

Families whose countable income is equal to or greater than 181% of the FPL shall be assessed a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition. Copayments are not assessed for Native American, Alaskan Native children, regardless of income. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions or,
3. Serious dysfunction of any bodily organ or part.

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☒ Premiums:

Premiums for participation in the dental-only supplemental program are assessed as follows:

a. No premium is charged to families whose countable income is less than 150 percent of the FPL.

b. If the family's countable is equal to or exceeds 150 percent of FPL, but does not exceed 200 percent of the FPL for a family of the same size, the premium is $5 per child per month with a $10 monthly maximum per family.
c. If the family's countable income exceeds 200 percent of the FPL, but does not exceed 250 percent of the FPL for a family of the same size, the premium is $10 per child per month with a $15 monthly maximum per family.
d. If the family's countable income exceeds 250 percent of the FPL, but does not exceed 300 percent of the FPL for a family of the same size, the premium is $15 per child per month with a $20 monthly maximum per family.
For families that include uninsured children who are eligible for both health and dental coverage under hawk-i and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:
a. The total premium shall be no more than what the family would pay if all the children were eligible for both health and dental coverage.
b. If the family has one child eligible for both health and dental coverage and one child eligible for dental-only supplemental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.
c. If the family has two or more children eligible for both health and dental coverage, no additional premium shall be assessed for dental-only supplemental coverage for the children who do not qualify for health coverage under hawk-i because they are insured.

Effective July 1, 2014, MAGI changed the FPLs for the dental only program as follows:
a. No premium is charged to families whose countable income is less or equal to 167 percent of the FPL.
b. If the family's countable income is above 167 percent of FPL and up to 204 percent of the FPL, the premium is $5 per child per month with a $10 monthly maximum per family.
c. If the family's countable income is at or above 205 percent of the FPL and up to 254 percent of the FPL, the premium is $10 per child per month with a $15 monthly maximum per family.
d. If the family's countable income is above 255 percent of the FPL and up to and including 302 percent of the FPL, the premium is $15 per child per month with a $20 monthly maximum per family.
For families that include uninsured children who are eligible for both health and dental coverage under hawk-i and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:
a. The total premium shall be no more than what the family would pay if all the children were eligible for both health and dental coverage.
b. If the family has one child eligible for both health and dental coverage and one child eligible for dental-only supplemental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.
c. If the family has two or more children eligible for both health and dental coverage, no additional premium shall be assessed for dental-only supplemental coverage for the children who do not qualify for health coverage under hawk-i because they are insured.

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))
Cost sharing is described in the Iowa Administrative Rules and in printed materials about the program, including the informational brochure that contains the application form. (See Attachment 7) Additionally, when approved, each family will receive an approval notice that lists their countable income calculation and the amount of cost sharing, if any.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))
There are only two forms of cost sharing in the hawk-i program, premiums and a copayment for treatment in an emergency room for a non-emergent medical condition. In both cases, they apply only to families with income that equals or exceed 181% of FPL.

A. Premiums: See Section 8.2.1 and Section 8.21.-DS.

B. Emergency copayment: For families that have health care coverage and their income is equal or exceeds 181% of the FPL, a copayment of $25.00 applies for inappropriate use of the emergency room. At current poverty levels, the family that pays premiums would have to incur the number of inappropriate emergency room visits indicated below to exceed 5%. MCOs are contractually required to track enrollee cost sharing to ensure that if the 5% quarterly limit is reached cost sharing is no longer collected and the co-payment is no longer deducted from claims reimbursement to providers. ~~Health~~

~~plans will report enrollee ER usage, resulting in a copayment obligation, to the third party administrator. The third party administrator will track the ER copayment to ensure cost sharing does not exceed 5% of the family income. At the point the ER copayment results in cost sharing exceeding 5%, enrollees will be reimbursed for the cost.~~

It is expected that the MCOs~~health plans~~ will intervene to educate enrollees about the appropriate use of ER services prior to any family utilizing the ER inappropriately in as many instances indicated in the chart.

No. of children in family	Annual Income at 302% FPL	5%	Premium Maximum	5% minus premium maximum	No. of Annual Inappropriate ER Visits
1	$35,545	$1,777.25	$240	$1,537.25	($1537.25/$25) 62
2	$48,109	$2,405.45	$480	$1925.45	($1925.45/$25) 77
3	$60,672	$3,033.60	$480	$2,553.60	($2553.60/$25) 102
4	$73,235	$3,661.75	$480	$3,181.75	($3181.75/$25) 127
5	$85.798	$4289.90	$480	$3809.90	($3809.90/$25) 152
6	$ 98,361	$4918.05	$480	$4438.05	($4438.05/$25) 178
7	$110,925	$5,546.25	$480	$5066.25	($5066.25/$25) 203
8	$123,488	$6,174.40	$480	$5,694.40	($ 5694.40/$25) 228

No cost-sharing is assessed for eligible Native American / Alaskan Native children regardless of family income for both the hawk-i program and the dental only program.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The brochure that contains the hawk-i application states that there is no cost sharing for American Indian/Alaskan Native children. At the time the applicant is approved for the hawk-i program, an approval notice is sent indicating there is no cost sharing. These provisions are also found in the Iowa Administrative Code at 441- 86.8(1).

Applications to the hawk-i program ask for the race of the children applying. When race is indicated as Native American or Alaska Native, no cost sharing is assessed to American Indian or Alaska Native children, regardless of income.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Premiums are due by the 5th day (or the next business day, if the 5th falls on a holiday or weekend) of the month prior to the coverage month. If the premium has not been received by the 5th or the next business day, if the 5th falls on a holiday or weekend, a reminder notice is sent. All notices of adverse action contain appeal rights language on the reverse side. The following example illustrates the actions associated with the premium for the coverage month of November.

Date	Action	Length of Time
September 21st	Invoice for November is sent	
October 5th	November premium is due	13 days from when the original invoice is sent.
October 6th	Reminder notice is sent if November premium is not received by October 5th	14th

day from when the original invoice is sent.
October 21st Invoice for November and December premiums due is sent This is the second invoice for the November premium, which is 17 days after the premium due date.
November 5th Notice of cancellation is sent for November premium and reminder notice sent for December premium if it is not received by November 5th. This notice is sent 30 days after the November premium is due. Coverage for November continues.
November 8th Notice of cancellation for November 30th is sent if the November premium was not received. This is 33 days after the November due date.
November 30th If the November premium has not been paid on or before November 30th, disenrollment occurs and there is no coverage beginning December 1st. This is 56 days after the November premium due date.

Initial Application: When an approval decision has been made on an initial application, the first premium due is for the third month of the twelve-month enrollment period.
Example: A child is approved on October 15th with an effective date of November 1st. The first premium is due on December 5th for the month of January.

Renewal Application: When an approval decision has been made on a renewal application, the first premium due is the first month of the new twelve-month enrollment period.
Example: The initial enrollment period ends November 30th. The renewal application is received in September and approved in September for a new enrollment period. The first premium due is October 5th for November (the first month of the enrollment period).

If a family reports a decrease in income and a premium is no longer required, premiums will no longer be charged beginning with the month following the month of the report of the change.
Any time an adverse action is taken such as disenrollment and cancellation from the program, the enrollee has the right to appeal the decision. The appeal rights and procedures are written on the backside of the notice. If the premium is not received by the tenth working day, the applicant is sent a notice of denial of eligibility. The applicant has the right to appeal this decision.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Objective One: Increase the health status of children in Iowa

Two: Increase the number of children who have access to health care.

Objective Three: Appropriate use of medications for children diagnosed with asthma.

Objective Four: Children participating in the Medicaid Expansion and hawk-i will have access to primary care practitioners.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Objective One: Increase the health status of children in Iowa.

Medicaid Expansion (M-CHIP) health status goals:

Health status and health care system measures will show acceptable incremental improvements for the following outcome measurements:

Healthy and Well Kids in Iowa (hawk-i) (S-CHIP):

Health status and health care system measures will show acceptable incremental improvements for the following outcome measurements:

1. Fifty percent of the children ages zero to 15 months enrolled in the hawk-i program will have at least one well-child visit.

2. Eighty percent of the children ages three, four, five and six years old enrolled in the hawk-i program will have well-child visits.

~~3. Send each family a health assessment questionnaire to complete for one child in the household. (Refer to Attachment 8).~~

Objective Two: Increase the number of children who have access to health care.

Medicaid Expansion (M-CHIP)

Enroll approximately 17,300 total children in the Medicaid expansion program.

hawk-i Program (S-CHIP)

Enroll approximately 31,300 children into health plans participating in the hawk-i program.

~~Objective Three: Appropriate use of medications for children diagnosed with asthma.~~

~~Medicaid Expansion (M-CHIP)~~

~~Sixty-five percent of children enrolled in the Medicaid Expansion program that have a diagnosis of asthma will have long-term control medications.~~

~~hawk-i (S-CHIP)~~

~~Fifty percent of the children enrolled in the hawk-i program that have a diagnosis of asthma will have long-term control medications.~~

Objective Three: Approprate use of medications for children diagnosed with asthma per the CMS CHIPRA measure.

Medicaid Expansion: Sixty-five percent of children enrolled in Medicaid Expansion that have a diagnosis of asthlma will have long-term control medications.
hawk-i: Fifty percent of the children enrolled in the hawk-i program that have a diagnosis of asthma will have long long-term control medications.

Objective Four: Children participating in the Medicaid expansion and hawk-i will have access to primary care practitioners.
Medicaid Expansion (M-CHIP)
Eighty-five percent of the children enrolled in the Medicaid expansion program will have access to a primary care practitioner.
hawk-i (S-CHIP)
Eighty-five percent of the children enrolled in the hawk-i program will have access to a primary care practitioner.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))
Assurance of an Objective Means for Measuring Performance
Iowa will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid databases that provide

relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Iowa's progress toward meeting the goal.

Objective One: Increase the health status of children in Iowa.
Measurement of Performance:

- ~~Every family approved for the hawk-i program will be asked to complete a health assessment questionnaire for one child in the household. (Refer to Attachment 8). The State has contracted with the Telligen (formerly Iowa Foundation for Medical Care) to analyze the results of the survey, both at the initial submission and the next review (12 months) when the family is asked to complete the survey on their past 12 month's experience.~~
- ~~Survey outcomes for hawk-i include:~~

~~1) Access to care (unmet need) and regular source of medical care,~~
~~2) ER use,~~
~~3) Unmet need and regular source of dental care,~~
~~4) Unmet need for vision care, pharmacy, and behavioral/emotional care,~~
~~5) Receipt of anticipatory guidance~~
~~6) Child's health status~~
~~7) Family environment (e.g., stress)~~

- Well-child visits in the third, fourth, fifth and sixth years of life will be measured using HEDIS measurements for both the Medicaid Expansion (M-CHIP) and hawk-i (S-CHIP) programs.

Objective Two: Increase the number of children who have access to health care.
Measurement of Performance:
Enrollment for the Medicaid expansion and the hawk-i programs will be measured using monthly enrollment reports.

Objective Three: Appropriate use of medications for children diagnosed with asthma.
Measurement of Performance
Medicaid Expansion (M-CHIP)
HEDIS measurement set relevant to children and adolescents younger than 21 without modifications.
hawk-i Program (S-CHIP)
HEDIS measurement set relevant to children and adolescents younger than 19 with modifications.

Objective Four: Children participating in the Medicaid Expansion (M-CHIP) and hawk-i (S-CHIP) programs will have access to primary care practitioners.
Measurement of Performance

HEDIS measurements with modifications for both the Medicaid Expansion (M-CHIP) and the hawk-i (S-CHIP) programs.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ ~~☒~~ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- **9.3.7.1.** ☒ Immunizations
- **9.3.7.2.** ☒ Well childcare
- **9.3.7.3.** ☒ Adolescent well visits
- **9.3.7.4.** ☐ Satisfaction with care
- **9.3.7.5.** ☐ Mental health
- **9.3.7.6.** ☒ Dental care
- **9.3.7.7.** ☐ Other, list:

9.3.8. ☒ Performance measures for special targeted populations.
The state is using the CHIPRA performance measure for asthma. ~~Asthma~~

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

Iowa's SCHIP annual report is completed by January 1 following the end of the Federal fiscal year utilizing the framework template developed by the National Academy for State Health Policy (NASHP). The report is completed by the State's EQRO.
The March supplement to the Current Population Survey (CPS) is utilized to calculate the baseline number of uncovered low -income children in Iowa.

~~The State has an approved Section 1915(b) waiver for Primary Care Case Management (PCCM). The State is responsible for assessment and evaluation under the PCCM waiver and intends to use the same investigator and contract for his Medicaid Expansion as used for the PCCM. The investigator (the Public Policy Center at the University of Iowa) will have access to Medicaid data and can develop measures such as number of office visits, continuity of care, and hospitalizations that would compare the newly enrolled group to the currently existing Medicaid population.~~

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

The initial implementation of hawk-i included public involvement through an appointed task force, public forums and the creation of the hawk-i Board (see 1.3). Rural and urban focus groups were also held to obtain input into the application and outreach materials.

There are two venues by which the public can provide input into any changes made in the hawk-i program:

1) The hawk-i Board meetings are held monthly and are open to the public. The agenda for the Board meeting is posted on the hawk-i website prior to the meeting. During each meeting time is allowed for public comment on any changes being proposed or any aspect of the program; or

2) Through the administrative rules process. The Administrative Procedures Act, Iowa Code Chapter 17A, requires all state agencies to promulgate rules for the operation of their programs. The rule-making process increases agencies' accountability to the public, allows public participation in the formulation of rules, and provides legislative oversight for program operations.

Before the Department's rules are adopted, they are published in the Iowa Administrative Bulletin as a

"notice of intended action." Any interested people may submit comments on the proposed rules within time frames set forth in the notice. All notices must allow at least 20 days for persons to submit comments or to request an oral presentation.
The Department may not adopt the rules until 35 days after the date the notice of intended action is published. Following notice and adoption, the final rules are again published in the Iowa Administrative Bulletin. They become effective at a date specified with the final rule. Normally the Department must allow at least 35 days from the date of publication for people to prepare to implement the rules.
The hawk-i Board first approves any proposed changes to the hawk-i administrative rules during public meetings. The rules then go through the Department's administrative rules process. The hawk-i Board must then approve the rules for a second time during a public meeting before they are adopted.

For implementation of the High Quality Healthcare Initiative, to implement MCOs within Medicaid and CHIP, on February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative (http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization). Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. On March 26, 2015, the DHS released an amended version of the RFP which incorporated changes based on stakeholder feedback. DHS continued to garner public input on the Initiative through public hearings and receipt of written comments.

Pursuant to State legislation (Senate File 505), DHS will also be conducting monthly statewide public meetings, beginning March 2016, to gather input from members, stakeholders, providers, community advocates and the general public on the managed care transition and implementation. All comments will be compiled and shared with the Iowa Medical Assistance Advisory Council (MAAC), which serves as an advisory forum on the health and medical care services provided under Medicaid. The MAAC Executive Committee will be responsible for assessing feedback received and making formal recommendations to DHS. The Executive Committee meets monthly and consists of members from both professional and consumer organizations, as well as the general public. Current organizational representation of the Executive Committee includes the Iowa Department of Public Health, the Iowa Hospital Association, the Iowa Health Care Association/Iowa Center for Assisted Living, the Iowa Medical Society, the Iowa Association of Community Providers, the Iowa Pharmacy Association, AARP, the Coalition for Family and Children's Services in Iowa, the Iowa Association for Area Agencies on Aging, and NAMI Iowa.

A member of the hawk-i Board will join the MAAC in August 2016. Comments and recommendations received by MAAC committee members will be shared with the state for review.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on

proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))
In addition to sending the proposed changes to our Administrative Rules to the tribes, the proposed rule changes are published in the Administrative Bulletin and are brought before the hawk-i Board meeting twice, one for noticing and once for adoption. Meetings of the hawk-i Board are open to the public and minutes of the meetings are posted on the hawk-i website for public access. Also, information on any programmatic changes to the hawk-i program is presented to the grassroots outreach coordinators who are required to work specifically with any tribes in their areas.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

The State has consulted with the Indian tribes and organizations regarding express lane eligibility.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane

Eligibility.

- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

CHIP Budget

STATE: Iowa	**FFY Budget**
Federal Fiscal Year	~~2015~~ 2016
~~State's enhanced~~ Enhanced ~~-~~FMAP rate	~~68.88%~~ 91.44%
Benefit Costs	
Insurance payments	~~$ 1,184,380~~ $1,184,000
Managed care	~~$111,055,165~~ $120,147,986
per member/per month rate	~~$ 235~~ $183
Fee for Service	~~$ 34,889,476~~ $13,066,036
Total Benefit Costs	~~$147,129,021~~ $134,398,022
(Offsetting beneficiary cost sharing payments)	~~$ (3,420,804)~~ $(3,359,197)
Net Benefit Costs	~~$143,708,217~~ $131,038.824
Cost of Proposed SPA Changes – Benefit	~~$ 0~~ $(16,108,143)
Administration Costs	
Personnel	~~$ 1,017,500~~ $346,000
General administration	~~$ 754,468~~ $530,582
Contractors/Brokers	~~$ 5,833,789~~ $6,723,858
Claims Processing	~~$ 2,479,975~~ $2,083,146
Outreach/marketing costs	$ 500,000
Health Services Initiatives	~~$992,000~~$829,209
Other	~~$ 759,597~~ 0
Total Administration Costs	~~$ 12,337,329~~ $11,012,795
10% Administrative Cap	~~$ 15,967,580~~ ~~7~~$14,559,869

STATE: Iowa	**FFY Budget**
Cost of Proposed SPA Changes	~~$992,000~~18,172,724)
Federal Share	~~$ 107,484,172~~ $129,892,001
State Share	~~$ 48,561,374~~ $12,159,619
Total Costs of Approved CHIP Plan	~~$156,045,546~~ $142,051,619

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State appropriations and county/local funds

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year, and 2) per member per month cost rounded to a whole number.
If you have SCHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2016	
	# of eligibles	$ PMPM
Insurance payments (supplemental dental)	3,462	28.50
Managed Care	55,857	179.25
Fee for Service	17,000	64.05

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan

under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

The Iowa Department of Human Services uses the same appeal process for all of its programs, including Medicaid and hawk-i eligibility and enrollment. This process is detailed in Attachment 9.

Express Lane Eligibility
If a child is found to be eligible for hawk-i from an initial Medicaid application, the child is granted eligibility subject to verification of citizenship and identification

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

~~The state is using the Statewide Standard Review. Section 514I.2(10) of the Iowa Code requires all participating health plans to be licensed by the Iowa Division of Insurance. All hawk-i enrollees receive services from health insurance issuers subject to state health insurance law. Managed care organizations are subject to Iowa Code Chapter 514B and indemnity health insurance carriers are subject to Iowa Code Chapters 505, 514. All health services are subject to an external review as described in Iowa Code Chapter 514J. See Attachment 10.~~A program specific review process is conducted. MCOs are required to operate a grievance and appeals process which addresses health services matters as defined at 42 CFR 457.1130. MCOs are required to allow members, or providers acting on the member's behalf, 30 days from the date of action notice within which to file an appeal. MCOs must provide the member and his representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents or records considered during the appeals process. In addition, the member and the member's representative have the opportunity to present evidence and allegations of fact or law in person as well as in writing.

The MCOs are required to establish a process to resolve appeals on an expedited basis when the standard time for appeal could seriously jeopardize the member's health or ability to maintain or regain maximum function. Expedited appeals must be resolved within seventy-two (72) hours from the request for an expedited appeal. MCOs must ensure individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the member's condition or disease if the decision will be in regard to any of the following: (i) an appeal of a denial based on lack of medical necessity; (ii) a grievance regarding denial of expedited resolution of an appeal; or (iii) any grievance or appeal involving clinical issues.

Non-expedited appeals must be resolved by the MCO within 45 calendar days. Members are notified in writing of the decision. If after exhausting the MCO grievance and appeals process the member remains dissatisfied with the outcome, he or she has the opportunity to appeal the MCO's decision to the State through the State Fair Hearing process, an independent external review.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

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GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.

21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
    (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term ‘Medicaid applicable

income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.

5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term 'child' means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term 'uninsured child' means a child that does not have creditable health coverage.