Iowa CHIP SPA #16
Redlined Version
April 6, 2011

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE 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))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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 J. Krogmeier	Position/Title: Director, Iowa Department of Human Services
Name: Jennifer Vermeer	Position/Title: Medicaid Director
Name: Anita Smith	Position/Title: Chief, Bureau of Adult and Child Medical Programs

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

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

1.1.3. ☒ A combination of both of the above.

1.1-DS ☒ The State will provide dental-only coverage. Only States operating a separate SCHIP program are eligible for this option. States choosing this option must also complete sections 1.4-DS, 4.1-DS, 4.2-DS, 4.3.1, 6.2–DS, 8.2-DS, and 9.10.1-DS of this SPA template.

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.
- The University of Iowa Public Policy Center: The Department of Human Services contracts 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 Iowa Foundation for Medical Care to conduct the analysis of the functional health assessment and analysis of the encounter data.

1.2 ☒ Please 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 ☒ Please 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)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: SCHIP State Plan- Medicaid Expansion 5-1-1998
Amendment 7 Expansion of counties for Iowa Health Solutions 6-1-2003

and elimination of 6-month waiting period 7-1-2003.

Amendment 8 Electronic Medicaid referral process 7-1-04, adding dental only plans 01-01-05, and withdrawal of Iowa Health Solutions 2-1-05

Amendment 9 Expansion of counties for John Deere and Delta Dental 3-1-06

Amendment 10 Name change for John Deere Health Plan. New name is AmeriChoice from UnitedHealthcare of the River Valley (AmeriChoice) 7-1-06; Addition of Wellmark Health Plan of Iowa (WHPI) health plan 7-24-06; Expansion of WHPI counties 9-1-06; Expansion of counties for AmeriChoice and Delta Dental Plan of Iowa counties 9-15-06.

Amendment 11 Expansion of counties for Wellmark Health Plan of Iowa 7-1-07

Amendment 12 Waiver of cost sharing premiums for families with countable income that equals exceeds 150% who are eligible for Iowa's disaster assistance for June and July 2008 - 6-1-08

Amendment 13 Increasing ***hawk-i*** income limits to 300% of the FPL. 7-1-09

Amendment 14 Coverage of Lawfully Residing Aliens 7-1-09
Withdrawal of Wellmark Blue Cross Blue Shield of Iowa (Classic Blue) 10-1-09;
Name change for AmeriChoice from UnitedHealthcare of the River Valley to UnitedHealthcare of the River Valley (UHC) 11-1-09;
Expansion of UHC, 3-1-10;
Changes to dental benefits, 3-1-10

Amendment 15 Presumptive Eligibility for Children, 3-1-10

Amendment 16 Express Lane Eligibility, 7-1-10

Implementation date:

Amendment 7 Expansion of counties for Iowa Health Solutions 6-1-2003 and elimination of 6-month waiting period 7-1-2003

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Expansion of UHC, 3-1-10;
Changes to dental benefits, 3-1-10

Amendment 15 Presumptive Eligibility for Children, 3-1-10

Amendment 16 Express Lane Eligibility, 7-1-10

1.4-DS For dental-only supplemental coverage, please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: 3-1-10
Implementation date: 3-1-10

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (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 1990's is confined to two areas: in and around Des Moines, and in the Cedar Rapids/Iowa City corridor. At the same time, 45 of Iowa's 99 counties are losing population. Data from 1994 suggests that 44 percent of Iowans live inside a metropolitan area.

According to the 2000 U.S. Census, Iowa has a population of 2,926,324 with 23.8% (827,983) being children ages 19 and younger. The Census reports show 11.5% of Iowa's population or 336,527 people living below poverty. In general, the highest levels of poverty are in the southern counties along the Missouri border.

While approximately 2,747,818 (93.9%) of Iowa's population are white and 61,423 (2.3%) 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 90.9% white, 3% black or African American, 0.4% American Indian or Alaska Native, 2% are of other race and 2.2% are two or more races. There are 36,263 Hispanic 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	773
All other ethnicities	719
Near East	
Iraqi	144
All Others	99
Former Soviet Union	
All ethnicities	443
Eastern Europe	
Bosnian	4,611
Kosovar	185
All other ethnicities	361
Southeast Asia	
Vietnamese	7,383
Tai Dam	2,740
Lowland Lao	3,281
Cambodian/Khmer	840
Hmong	423
Latin America/Caribbean	
Haitian	32
All other ethnicities	5
TOTAL	**21,988**

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 1,277 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, have resulted in a significant growth trend and 200% birth rate increase since 1992. According to the 2000 U.S. Census, 8,989 people identified themselves as Native American or Alaska Native. Of this number 39.1% are 19 years of age or younger.

The only public health insurance program generally available in Iowa is Medicaid. In April 2002, there were 129,192 children (66,369 male/ 62,823 female) 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.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered 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.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered 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.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

At the time a child is determined not to be eligible for ***hawk-i***, the letter the applicant receives states: "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.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ 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.

3.1. 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))

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.

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))

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.

Section 4. Eligibility Standards and Methodology. ***(Section 2102(b))***

☐ 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 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1-DS 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 SCHIP plan income eligibility level must be at least 200 percent of the FPL 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**.**

4.1.1. ☒ Geographic area served by the Plan:

Effective July 1, 2009:

- Wellmark Health Plan of Iowa (WHPI) is providing health care coverage in all Iowa Counties:
- Delta Dental of Iowa is providing dental care coverage in all Iowa counties.
- WHPI and Classic Blue are no longer providing dental care coverage.
- UnitedHealthcare is providing health care coverage in the following 53 Iowa counties:

Iowa Counties

Appanoose	Clinton	Iowa	Lucas	Wapello
Black Hawk	Dallas	Jackson	Madison	Warren
Benton	Davis	Jasper	Marion	Washington
Boone	Delaware	Jefferson	Monroe	Wayne
Bremer	Dubuque	Johnson	Muscatine	
Buchanan	Fayette	Jones	Polk	
Butler	Greene	Keokuk	Poweshiek	
Carroll	Grundy	Lee	Scott	
Cedar	Guthrie	Linn	Story	
Clayton	Henry	Louisa	Van Buren	

Effective October 1, 2009: Classic Blue (Wellmark Blue Cross Blue Shield of Iowa) is no longer participating with the ***hawk-i*** program.

Effective March 1, 2010: UnitedHealth care is providing health care coverage in all Iowa counties.

See Attachment 13 for a map showing the counties and the corresponding health and dental plans.

4.1.2. ☒ Age: Under ***hawk-i,*** children up to the age of 19 are covered. Coverage ends effective the first day of the month following the month of the nineteenth birthday.

4.1.3. ☒ Income: Effective July 1, 2000, under ***hawk-i***, countable earned and gross unearned income cannot exceed 200% of the FPL for family of the same size. Effective December 1, 1999, 20% of earned income (including self-employment income) will be exempt when determining family income for the ***hawk-i*** program.

Effective February 1, 2000, income from self-employment: under ***hawk-i***, income from self-employment will be the gross income minus the cost of doing business. This includes the depreciation of capital assets as identified for income tax purposes.

Effective July 1, 2009, when determining eligibility, all income between 200 percent and 300 percent of the FPL shall be disregarded.

4.1.4. ☐ Resources (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): Iowa. There is no minimum period of time in which the child must reside in the State to establish 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: Eligibility for ***hawk-i*** is granted in 12-month enrollment periods. At the end of the 12 months, a review is completed to establish eligibility for the next 12-month enrollment period.

4.1.9. ☒ Other standards (identify and describe):

Pregnancy. During the 12-month enrollment cycle, if an adolescent enrolled in the ***hawk-i*** program becomes pregnant, information about the Medicaid program is provided to the pregnant adolescent or her family. However, the pregnant child is not automatically transferred to the Medicaid program. If the adolescent or her family applies for Medicaid and Medicaid eligibility is approved, ***hawk-i*** eligibility ends. If the child or her family do not apply for Medicaid, eligibility will continue under ***hawk-i*** until the next annual renewal. If, at the next annual renewal, the adolescent is still pregnant, the renewal is referred to Medicaid for a Medicaid eligibility determination.

Inmates of nonmedical public institution. At the time of application or annual review of eligibility, the child shall not be an inmate of a nonmedical public institution as defined 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 as defined at 42 CFR 435 Section 435.1009 as amended November 10, 1994.

Express Lane Eligibility

A. For Medicaid

The express lane eligibility agency for Medicaid is Supplemental 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.

B. For ***hawk-i*** (CHIP)

The express lane eligibility agency for the ***hawk-i*** program is Iowa Medicaid. When a child is determined ineligible for Medicaid because they are over income at ~~either~~ initial application ~~or renewal~~, the Medicaid eligibility system automatically takes the eligibility worker to a screen on which to make an 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 regarding the family and household income is electronically transferred to the Third Party Administrator's (TPA) proprietary 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 ineligibility is accepted by the TPA to 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 period has not previously been provided, the child is enrolled in the program and a 90-day period in which to verify 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.

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

4.1.10 __X___ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible and

children as specified below who are lawfully residing in the United States including the following:

A child 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 least 180 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.

X_ **The State elects the CHIPRA section 214 option for children up to age 19**
_____**The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period**

4.1.10.1__X___ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at 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.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 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.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.2-DS For dental-only supplemental coverage, the State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 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. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Presumptive Eligibility

Staff of qualified entities selected and trained by the Medicaid state agency

are authorized to determine presumptive eligibility. The process for completing a presumptive eligibility application is described in Attachment 17. 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.

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. (See Attachment 2)

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. See Attachment 14 for the list of Iowa counties effected as of June 30, 2008.

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.

<u>Ongoing Eligibility During the 12-Month Enrollment</u>

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.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state. A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

Refer to response in 4.3.

Express Lane Eligibility

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

Refer to response in 4.1.9 Express Lane Eligiblity.

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.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Refer to response in 4.3.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (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. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

A child who is currently enrolled in an individual or group health plan is not eligible to participate in the ***hawk-i*** program. **Exception:** A child who is enrolled in a single service plan that provides coverage only for a specific disease or service (e.g. dental only or vision only) is considered uninsured for the purpose of establishing ***hawk-i*** eligibility.

Effective July 1, 2003, the State no longer imposes a 6-month waiting period for children who have been insured through an employer group health plan in the six months prior to the month of application. Iowa House File 565 included provisions that require the Department to monitor the effects of eliminating the 6-month waiting period and report back to the General Assembly on the findings. The state is continuing to ask insurance history questions on the application form and the information is being tracked by the state's third party administrator. A quarterly report will identify the impact of this change on the program and be reported to the General Assembly.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

See response to 4.4.4.3

4.4.4.3. ☒ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

A match with insurance carriers is done at application to determine if the child has other health insurance. The report indicates if there is other health coverage, the effective date of the coverage and the date the coverage ended if applicable.

To be eligible, a child whose family's income is from 251 to 300% FPL, must not have dropped health insurance coverage in the month prior to the month in which the child would otherwise be eligible. If health insurance was dropped, the effective date of the ***hawk-i*** coverage will be delayed by one (1) month.

Children who have lost health insurance coverage due to one of the following reasons will not be subject to the one (1) month waiting period.

1. The child is moving from Medicaid to ***hawk-i***.
2. The child has a chronic or emergent medical condition.
3. The cost of the health care coverage for the child exceeded 5% of the family's gross income. Cost of the health care coverage for the child shall be the difference between the premium for coverage with and without the child.
4. The health care coverage was provided through an individual plan.
5. The child's health care coverage was lost due to:
   a. Domestic violence
   b. Divorce or death of a parent
   c. An involuntary loss of the parent's employment, including, but not limited to layoff, business closure, reduction in hours, termination, etc.
   d. A change in the parent's employer to one who does not offer dependent coverage or requires a waiting period longer than 30 days before the child can be enrolled.
   e. The child reached the maximum lifetime coverage benefit.
   f. Expiration of coverage under COBRA.
   g. The parent's employer discontinuing the availability

of dependent coverage.

h. A reason beyond the control of the parent such as serious illness of the parent, natural disaster, fire, flood, etc.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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 the ***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.

Section 5. Outreach (Section 2102(c))

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)

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)

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)**

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 Mar**maxx**

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 ZLR*IGNITION* (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.

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. 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***.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ 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 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

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

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

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

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.)

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

See Attachment 3 for the benchmark plan.

Effective October 1, 2009, the following health plans are participating in the ***hawk-i*** program.

- UnitedHealthcare Plan of the River Valley
- Wellmark Health Plan of Iowa

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

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 offered 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 project

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

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

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 (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

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 prepregnancy 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))

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

6.2.15. ☒ Nursing care services (See instructions) (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))
Refer to 6.2.-D for details.

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))

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (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))

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (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.-DS ☒ 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 2103(a)(5):

6.2.-D The State will provide dental coverage to children through one of the following. 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.-D ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) 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

6.2.1.2-D 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)

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

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

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

6.2.2.2-D ☐ 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, please also attach a description of the services and applicable CDT codes)

6.2.2.3.-D ☐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, please also attach a description of the services and applicable CDT codes)

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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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% 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))

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))

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 relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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))

Section 7. Quality and Appropriateness of Care

☐ 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.

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. (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 (DHS) encourages all contracted managed health plans to pursue National Committee for Quality Assurance (NCQA) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification.

7.1.2. ☒ Performance measurement

Refer to Section 9.1

The ***hawk-i*** Functional Health Assessment Survey
The report presents the results of an ongoing evaluation of the impact of the Healthy and Well Kids in Iowa (***hawk-i***) Program on the access to and health status of enrolled children. The first evaluation, parents' responses to a survey given at the time they joined the program (the baseline survey) are compared with their responses to a survey given after their child has been enrolled for about a year (the follow-up survey) to determine if there are differences in the perceived ability to receive health services or in their child's health status. Also included in the follow-up survey and presented in the report are questions specific to ***hawk-i***, such as ratings to the private health plans that contact with ***hawk-i*** and the impact of having health insurance.

7.1.3. ☒ Information strategies

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 used for assistance to

obtain 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 sue of non-participating providers;
- access of after-hours care;
- enrollee rights and responsibilities;
- procedures for notifying enrollees of changes in the benefits or delivery of services; and
- procedures for recommending changes in policies and procedures.

7.1.4. ☒ Quality improvement strategies
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 aspects 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 nine-member committee is comprised of community medical professionals representing pediatricians, family practice, dental, mental health, nutrition and pharmacy.

7.2. Describe the methods used, including monitoring, to assure: (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 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 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 July 1, 2005, the Department has a contract with Iowa Foundation for Medical Care to validate the encounter claims data with a medical record review.

hawk-i's Functional Health Assessment Survey is an excellent tool to evaluate health status of children enrolled in the ***hawk-i*** program.

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 IFMC contract. 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 plans are contractually required to include written procedures in the member handbook on accessing emergency services.

Contracted health and dental plans are required to submit complaint/grievance reports to the Department on a quarterly basis. Additionally, 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))

Contractually, health plans are required to ensure patient care that is coordinated and continuous, including at a minimum:

- systems to assure timely and appropriate referrals for Medically Necessary, specialty, secondary and tertiary care including subspecialization for pediatric care as well as health education services for members; and

- systems to assure provision of care in situations requiring treatment for an emergency medical condition, including an education process to help assure that members know where and how to obtain medically necessary care in an emergency.
- systems to assure that the plan shall not limit providers from disclosing all information about services available to the member related to their medical condition irrespective of the plans coverage or provider network.

Iowa House File (HF2517), the bill that created the ***hawk-i*** program, mandated that a Special Needs Committee be established to make recommendations to the board and to the general assembly concerning the provision of health insurance coverage to children with special health care needs under the program. The purpose of the Committee is to address the following:

1) Define the target population of children with special health care needs for the purposes of determining eligibility under the program.
2) Eligibility options for and assessment of children with special health care needs for eligibility.
3) Benefit options for children with special health care needs.
4) The appropriateness and quality of care for children with special health care needs.
5) Coordination of health services provided for children with special health care needs under the program with services provided by other publicly funded programs.

The Special Needs Committee has periodic meetings with contracted health plans to discuss case management services for members with long-term health care needs.

The Functional Health Assessment Survey asks questions related specifically to a child with chronic medical conditions (see 7.1.2).

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))

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."

Section 8. Cost Sharing and Payment *(Section 2103(e))*

☐ 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)

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

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 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) &(c), 457.515(a)&(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.

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 150% 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: None

8.2.3. Coinsurance or copayments:
Families whose countable income is equal to or greater than 150% 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 For children enrolled in the dental-only supplemental coverage, please describe the amount of cost-sharing, specifying any sliding scale based on income. Please 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))

8.2.1.-D 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.

8.2.2.-D Deductibles: There are no deductibles for the dental-only supplemental coverage.

8.2.3.-D Coinsurances or copayments: There are no coinsurances or copayments for the dental-only supplemental coverage.

8.2.4.-D Other: No cost-sharing is assessed for eligible Native American / Alaskan Native children regardless of family income.

The maximum total cost-sharing for a family may have is $40 per month or $240 per 12-month enrollment period. See response to 8.5 below regarding the 5 percent income limit for cost sharing.

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)(B)) (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.

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 150% of FPL.

A. Premiums
There are three premium tiers based on family income and the benefits received.

a. Premiums for full coverage (medical and dental) in the ***hawk-i*** program are:

i. 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.

ii. 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.

b. Premiums for dental-only supplemental coverage are:

i. If the family's countable income equals or exceeds 150% of the 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.

ii. 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.

iii. 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.

Since the premiums are the only cost sharing incurred by the family, the annual cost sharing will not exceed 5% of the family's income. See response in 8.2.4 D.

c. Premiums for families that include children who are eligible for both health and dental coverage under ***hawk-i*** and insured children who are eligible only for dental coverage are:

i. 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.

ii. If the family has one child eligible for both health and dental coverage and one child eligible for dental-only supplemental coverage, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

iii. 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 because they are insured.

B. Emergency copayment: For families that have health care coverage and their income is equal or exceeds 150% 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%. 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 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 300% FPL	5%	Premium Maximum	5% minus premium maximum	No. of Annual Inappropriate ER Visits
1	$32,490	$1,624.50	$240	$1,384.50 ($1384.50/$25)	55
2	$43,710	$2,185.50	$480	$1,705.50 ($1705.50/$25)	68
3	$54,930	$2,746.50	$480	$2,266.50 ($2266.50/$25)	91
4	$66,150	$3,307.50	$480	$2,827.50 ($2827.50/$25)	113
5	$77,370	$3,868.50	$480	$3,388.50 ($3388.50/$25)	136
6	$88,590	$4,429.50	$480	$3,949.50 ($3949.50/$25)	158
7	$99,810	$4,990.50	$480	$4,510.50 ($4510.50/$25)	180
8	$111,030	$5,551.50	$480	$5,071.50 ($5071.50/$25)	203

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. Please 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.

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.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ 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))
- ☒ 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))
- ☒ 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))
- ☒ 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, copays, 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 (Section 2107)

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 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.

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 Four: 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.

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 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, please list:

9.3.8. ☒ Performance measures for special targeted populations.

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)

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 March supplement to the Current Population Survey (CPS) is utilized to calculate the baseline number of uncovered low-in 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 of audit. (Section 2107(b)(3)) (42CFR 457.720)

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)

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 insuring 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.

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. (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.

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

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

See the response for 9.9.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. 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 sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

9.10.1-DS Please include a separate budget line to indicate the cost of providing dental-only supplemental coverage.

~~**SCHIP Budget Plan FFY 10**~~ ~~SPA 13~~ ~~SPA 15~~ increase
~~**IOWA - for expansion presumptive eligibility**~~

-	~~**Federal Fiscal Year Costs**~~	~~**Federal Fiscal Year Costs**~~	**Federal Fiscal Year Costs**
~~Enhanced FMAP rate~~	~~**74.46%**~~	~~**74.46%**~~	**74.46%**
~~**Benefit Costs**~~	-	-	
~~**Population 1 - *hawk-i* - Iowa's stand alone program**~~	-	-	
~~Insurance payments~~	~~$17,842,100~~	~~$17,842,100~~	$0
~~Managed care~~	~~$40,511,475~~	~~$40,511,475~~	$0
~~per member/per month rate @ # of eligibles~~	~~$218~~	~~$218~~	
~~Fee for Service~~	~~$0~~	~~$0~~	
~~per member/per month rate @ # of eligibles~~	~~n/a~~	~~n/a~~	
~~Benefit Costs subtotal popuation 1~~	~~**$58,353,575**~~	~~**$58,353,575**~~	**$0**

Population 2 - expanded Medicaid	-	-	
- Managed care	$0	$0	$0
per member/per month rate @ # of eligibles	n/a	n/a	
- Fee for Service	$29,740,541	$29,886,689	$146,148
per member/per month rate @ # of eligibles	$173	$173	
Benefit Costs subtotal popuation 2	**$29,740,541**	**$29,886,689**	**$146,148**
Total Benefit Costs	**$88,094,116**	**$88,240,264**	**$146,148**
(Offsetting beneficiary cost sharing payments)	-$1,758,543	-$1,758,543	$0
Net Benefit Costs	**$86,335,573**	**$86,481,721**	**$146,148**
Administration Costs	-	-	
Personnel	$459,188	$459,188	$0
General administration	$569,591	$569,591	$0
Contractors/Brokers (e.g., enrollment contractors)	$3,228,080	$3,235,705	$7,625
Claims Processing	$1,700,726	$1,700,726	$0
Outreach/marketing costs	$852,584	$852,584	$0
Benefits to clients (Health Initiative dollars)	$0	$3,747	$3,747
Other (cost allocation)	$953,486	$953,486	$0
Total Administration Costs	**$7,763,655**	**$7,775,027**	**$11,372**
10% Administrative Cost Ceiling	$9,592,841	$9,609,080	$16,239
-	-	-	
Federal Share (multiplied by enh-FMAP rate)	$70,066,285	$70,183,574	$117,289
State Share	$24,032,943	$24,073,173	$40,231
TOTAL PROGRAM COSTS	**$94,099,228**	**$94,256,748**	**$157,520**

NOTE 1: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

2. What were the sources of non-Federal funding used for State match during the reporting period?

XX	State appropriations
-	County/local funds
-	Employer contributions
-	Foundation grants
-	Private donations
-	Tobacco settlement
-	Other (specify) **[500]**

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.

	2010	
	# of eligibles	$ PMPM
Insurance payments	6,680	$ 223

~~Managed Care~~	~~15,586~~	~~$ 217~~
~~Fee for Service~~	~~14,357~~	~~$ 173~~

CHIP Budget Plan FFY 11 IOWA – SPA 16 for express lane eligibility*

	Federal Fiscal Year Costs
Enhanced FMAP rate	73.84%
Benefit Costs	
Population 1 - *hawk-i* - Iowa's stand alone program	
Insurance payments	$0
Managed care	$81,232,746
per member/per month rate @ # of eligibles	$211
Fee for Service	$0
per member/per month rate @ # of eligibles	n/a
Benefit Costs subtotal population 1	**$81,232,746**
Population 2 - Supplemental Dental	
Insurance payments	$1,358,882
per member/per month rate @ # of eligibles	$30
Benefit Costs subtotal population 2	**$1,358,882**
Population 3 - expanded Medicaid	
Managed care	$0
per member/per month rate @ # of eligibles	n/a
Fee for Service	$31,736,680
per member/per month rate @ # of eligibles	$168
Benefit Costs subtotal popuation 3	**$31,736,680**
Total Benefit Costs	**$114,328,308**
(Offsetting beneficiary cost sharing payments)	-$3,099,425
Net Benefit Costs	**$111,228,883**
Administration Costs	
Personnel	$472,964
General administration	$759,664
Contractors/Brokers (e.g., enrollment contractors)	$4,350,227
Claims Processing	$1,829,647
Outreach/marketing costs	$1,481,078
Other (cost allocation)	$920,000
Total Administration Costs	**$9,813,580**
10% Administrative Cost Ceiling	$12,358,765
Federal Share (multiplied by the-FMAP rate)	$89,377,755
State Share	$31,664,708
TOTAL PROGRAM COSTS	**$121,042,463**

NOTE 1: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

2. What were the sources of non-Federal funding used for State match during the reporting period?

XX	State appropriations
-	County/local funds
-	Employer contributions
-	Foundation grants
-	Private donations
-	Tobacco settlement
-	Other (specify) **[500]**

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 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.

-	2011	
	# of eligibles	$ PMPM
Insurance payments	-	$ -
Managed Care	31,986	$ 211
Fee for Service	15,769	$ 168
Supplemental dental insurance payments	3,771	$ 30

*This budget reflects the costs of Iowa's CHIP for FFY 11. There is no additional cost for Express Lane Eligibility for SPA 16. The State is aware that there is a potential for a shortfall in FY '11 and possibly FY'12. The State is working with CMS to resolve this issue.

Section 10. Annual Reports and Evaluations (Section 2108)

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 uncovered 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-D ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

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 items 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 with 42 CFR 457.1120.

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.

12.2. Health Services Matters

Please describe the review process for health services matters that comply 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.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please 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.

Attachment 2 Referral Process

Enrollment Process for *hawk-i*

Application is received by the Third Party Administrator (TPA)

Steps	Yes	No	Unknown
1. Is the application signed?	Application is date stamped, logged into the TPA's system and screened for Medicaid eligibility within 24 hours of receipt.	Return application for signature within 24 hours.	
2. Does Medicaid eligibility appear to exist?	Send referral to co-located Income Maintenance Workers (IMW) for Medicaid eligibility determination using Medicaid policies and procedures.	Determine eligibility for ***hawk-i*** within 10 working days of receiving a complete application. • If ***hawk-i*** eligibility <u>does not</u> exist then deny application. • If ***hawk-i*** eligibility <u>does</u> exist then notify family of plan choices and cost sharing obligation if applicable.	Insufficient information to make determination. Request additional information. • If requested information <u>is not</u> received timely, deny application. • If requested information <u>is</u> received then determine if Medicaid eligibility exists and follow Yes and NO section of step 2.
3. Are the children eligible for Medicaid?	Children are enrolled in Medicaid.	Go to Step. 4.	If no action has been taken on the application within 30 days, the TPA will follow-up with the co-located IMW for status.
4. Was the application denied because of failure to cooperate with Medicaid?	Deny application for ***hawk-i*** coverage.	Go to Step. 5	
5. Was the application over income for Medicaid?	Determine eligibility for ***hawk-i*** within 10 working days of receiving the Medicaid decision. • if ***hawk-i*** eligibility <u>does</u> exist then notify family of plan choices and cost sharing if applicable. • if ***hawk-i*** eligibility <u>does not</u> exist, deny application.		

Referral Process from DHS to *hawk-i*

<u>When Medicaid Application is Denied</u>

1. Family applies for Medicaid at DHS office
2. The application is denied due to excess income.

3. DHS completes an electronic or paper referral and sends the referral to ***hawk-i***. (This occurs even if the Income Maintenance Worker is simultaneously determining Medically Needy eligibility with a spenddown.

When there is an existing Medicaid case at the DHS office

1. An ongoing Medicaid case is canceled due to excess income.
2. DHS completes an electronic or paper referral and sends the referral to ***hawk-i***. (This occurs even if the Income Maintenance Worker is simultaneously determining Medically Needy eligibility with a spenddown.

For both situations, the TPA:

1. Logs the referral into the TPA system.
2. Proceeds with the ***hawk-i*** eligibility determination.

Iowa Department of Human Services

REFERRAL TO THE *hawk-i* PROGRAM

☐ Denied Application/Individual (provide Medicaid application date) ☐ Canceled Case/Individual

Date:		Case Name:	
Worker Name:	Worker Number:	Case Number:	
Worker County:	Worker Phone:	Case Phone:	County of Residence:

People in Household	Social Security Number	Birth Date	Sex	Citizen (If No, explain alien status in Comments)	How Related to Case Name (spouse, parent, child, etc.)	Medicaid End Date (only on canceled cases or individuals)	Language Preference	If child, do they have health insurance coverage?
1.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
2.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
3.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
4.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
5.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
6.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No
7.			☐ M ☐ F	☐ Yes ☐ No			☐ English ☐ Spanish ☐ Other:	☐ Yes ☐ No

Effective Date: 71 Approval Date:

This case is being referred to *hawk-i* because:

☐ The children must meet a spenddown under the Medically Needy program.

☐ The following children have been voluntarily excluded from the Medicaid eligible group because the **child's income** creates Medicaid ineligibility for the remaining household members. ***Indicate the income of the voluntarily excluded child below in the next section. Also, attach an NOD showing the Medicaid eligibility calculation for the other family members.*** (**Note:** Children voluntarily excluded for non-financial reasons are not eligible for ***hawk-i***.)

1. 2.

3. 4.

Income

☐ Family members are employed at the following companies:

☐ Family members have unearned income from the following sources:

This case has (check all that apply):

☐ Non-recurring lump sum Income:

Amount prorated monthly (Standard of Need): $

Last month and year of period of proration: (MM/YYYY)

☐ Self-employment income:

Amount of depreciation (from Schedule C or (or attach a copy of Schedule C or F) $

☐ Unemployment benefits:

Name of person(s) receiving UIB:

☐ Income of voluntarily excluded child:

$ per (week, month, etc)

☐ Income has been verified (attach verification to referral)

☐ Income has not been verified

Attachments: ☐ Copy of Notice of Decision showing Medicaid ineligibility (**Required**)

Comments

REMINDER – Only Refer Children Who Are Over Income For Medicaid

Do Not Refer Children to the *hawk-i* Program Who:

- Are age 19 or older; **or**
- Are ineligible for Medicaid due to a non-cooperation issue.

Send via local mail to:
Department of Human Services
Attn: MAXIMUS/***hawk-i*** Program
Division of Financial, Health and Work Supports
1305 E. Walnut
Des Moines, IA 50319-0114 **OR**
Fax: 515-457-7701

hawk-i Referral Process
A Desk Guide for Income Maintenance Workers

Policy: Refer children under age 19 to the ***hawk-i*** program when any child for whom a family is applying is over income for Medicaid or is conditionally eligible for MN. (Employees' Manual Chapters 8-B & 8-G)

Making a Referral:

Referring a Denied Application	Referring a Cancelled Case
To refer an application that has been denied or an application that has been approved only for MN with a spenddown: ❑ Fill out the referral form* and send it to ***hawk-i*** with copies of: 1. the Medicaid application 2. the income verification 3. the notice of decision ❑ Make the referral within one working day from the time that you know that the child is not eligible for Medicaid or that they must meet a spenddown under Medically Needy. ❑ The Medicaid application date will become the ***hawk-i*** filing date.	To refer a case that has been cancelled or must now meet a spenddown under MN: ❑ Fill out the referral form* and send it to ***hawk-i*** with copies of: 1. the income verification 2. the notice of decision ❑ Make the referral within one working day from the time that you know that the child is not eligible for Medicaid or that they must meet a spenddown under Medically Needy. ❑ If eligible, there will be no break in coverage for children moving from Medicaid to ***hawk-i.***
The family does not have to fill out a separate ***hawk-i*** application.	

* "Referral to the Healthy and Well Kids in Iowa (***hawk-i***) Program," form 470-3565, is available in State Approved Forms on Outlook.

Send the referral and accompanying verification to: (Do not send case records or original application forms)

Interoffice Mail: Department of Human Services
Attn: MAXIMUS/***hawk-i*** Program
IME
100 Army Post Road
Des Moines, IA 50315

OR **FAX:** 515-457-7701

*Questions? Call **hawk-i** Customer Service: 1-800-257-8563*

OVER

Helpful Hints:

- If a case goes over income because of a lump sum period of proration, but the children would otherwise be Medicaid eligible, note in the comments section of the referral form that there is a lump sum, how much it is, and when the period of proration ends.

- If a child is voluntarily excluded from Medicaid because of the child's income, refer the child to ***hawk-i***. Note in the upper right corner of the back page of the referral that the child is excluded and include their income information.

- Do not refer children to ***hawk-i*** if the child has been voluntarily excluded from Medicaid for reasons other than the child's income.

- Do not refer children to ***hawk-i*** when the reason they are not eligible for Medicaid is due to non-cooperation (e.g. failure to return review forms, failure to provide verification, etc.).

- Self-employment: ***hawk-i*** allows a deduction for depreciation of capital assets for self-employment while Medicaid does not. In this situation, include the appropriate Schedule C or F when making the referral.

- Unemployment: Medicaid looks at unemployment as a weekly benefit. ***hawk-i*** looks at the maximum benefit the person can receive and uses it to project income for the 12-month enrollment period. Include the DBRO screen front page (from IWD system) when referring these cases to ***hawk-i***. Indicate in the comments section if there is any other unearned income on the NOD so it gets used.

- When you make a referral and give the family a ***hawk-i*** brochure for informational purposes, take the application out of the brochure so they don't think they have to apply separately. This will help avoid duplicate applications being filed.

hawk-i Customer Service: 1-800-257-8563 (TDD: 1-888-422-2319) www.hawk-i.org

Attachment 10 Plan Appeal and Grievance Procedures

	UnitedHealthcare	Wellmark Health Plan of Iowa	Delta Dental of Iowa
Definition	Any questions or concerns regarding coverage decisions, preauthorization decisions, or any action concerning the provision of health care services, or other matters concerning the operations of health plan.	Denial of benefits, or disagreement with decision to reduce benefits, or complaint regarding a claim, provider or service provided by Wellmark	Denial or partial denial, or a complaint regarding a claim.
Who can file a complaint or an appeal	An Enrollee's physician, family member or other individual may act as the Enrollee's representative to assist in filing a complaint on behalf of the Enrollee.	Enrollee or someone appointed by the Enrollee.	The Enrollee, a representative of the Enrollee, or the dentist.
Type of appeal			
Informal	Enrollee contacts Customer Service Department or other health plan employee with an inquiry.	Enrollee calls Customer Service Department	Enrollee calls Customer Service Department
Decision maker	Customer service department. If Enrollee is dissatisfied with the response, the enrollee must always be advised of next step in complaint process.	Customer service department researches and resolve issue and notify Enrollee of right to appeal if appropriate	Customer Service Department. If Enrollee disagrees with the decision, enrollee can receive a full and fair review.
Standard or First Level Appeal Process	Used for all cases that are not life threatening or severe enough to seriously jeopardize the member's health and/or ability to regain maximum function. Written expression of dissatisfaction with health plan requesting that a decision be overturned.	If enrollee is not satisfied with resolution of a complaint, enrollee may contact customer service department by phone or submit a written appeal by completing an Enrollee Appeal Form.	The enrollee may submit a written request of review and appeal. The written request should have the reason for the request, documents, records and any other information related to the claim.
Time frames for filing an appeal	Complaint form shall be filed within 90 days from date the problem in question occurred. The form shall be signed and the facts listed.	The Enrollee Appeal Form must be filed within 120 days of the complaint decision.	The written request should be submitted within 180 days from the notice of denial.

	UnitedHealthcare	Wellmark Health Plan of Iowa	Delta Dental of Iowa
Decision maker	Health plan's medical director or physician advisor when medical review is needed or appropriate. When the issue requires an administrative the appropriate department makes the decision. Persons involved in the initial determination may not review the appeal.	Wellmark Blue Cross and Blue Shield Enrollee Appeal Committee	Delta Dental Appeal Committee.
Time frame for decision	Within 30 calendar days of receipt of complaint with details of the decisions and further appeal process available to Enrollee, should decision not be in Enrollee's favor. The written decision may be extended by ten business days to obtain documentation records necessary to resolve the case and the delay is in the interest of the Enrollee.	30 calendar days from receipt of form, if no additional information is needed. If additional information is not received in time allowed, Wellmark will make a decision.	Within 30 days of receiving the request.
Notification of decision	Written letter to all parties involved.	Written letter to all parties involved. .	Written letter to all parties involved.
Expedited Appeal	Requested to accommodate the urgency of the situation when the standard appeal process will cause delay in the rendering of health care that would be life threatening or severe enough to seriously jeopardize the member's health and/or ability to regain maximum function.	May be requested anytime there is denial in utilization management and the situation is urgent.	May be requested if the situation is urgent.
Who can file a complaint or an appeal	Enrollee or physician contacts UHC verbally or in writing with request for expedited appeal. An enrollee's physician, family member or other individual may act as the Enrollee's representative to assist in filing an appeal on behalf of the Enrollee.	Enrollee, physician or hospital	The Enrollee, a representative of the Enrollee, or the dentist.
Decision Maker	Medical director or physician advisor	Medical director or physician advisor	Dental director or dental consultant.

	UnitedHealthcare	Wellmark Health Plan of Iowa	Delta Dental of Iowa
Time frame for decision to be made	Every attempt will be made to provide a decision for expedited appeals that are emergent in nature within 24 hour turnaround of receipt of complete medical information necessary to render a decision.	Within 72 hours of request	Every attempt is made to provide a decision as quickly as possible.
Notification of decision	The Enrollee will be informed of the decision by telephone or fax within 72 hours. In addition, a written decision is issued within 2 business days detailing the decision. If ruling is not in favor of the Enrollee, the Enrollee has 14 days to appeal the decision orally or in writing.	By phone or fax, followed by written decision.	By phone or fax, followed by a written decision.
Second Level Appeal	An appeal to Grievance Committee is a further request from an Enrollee than an unfavorable Level 1 complaint decision be reversed.	If not satisfied with the resolution of first level appeal, Enrollee may appeal to the Enrollee Appeal Committee of the Board.	A second request may be made if not satisfied with appeal decision.
Time frame to file a second level appeal	If the Enrollee is not satisfied with the outcome of the decision he/she has 14 days from the date the decision was issued in which to file a formal appeal to the Enrollee Grievance Committee of UHC.	Must be filed within 30 calendar days of receipt of decision	Must be filed within 30 days of receipt of the decision.
Decision maker	The Grievance Committee. Grievances will not be heard or voted upon unless at least 50% of the voting individuals of the committee are Enrollees who are consumers. The Grievance Committee shall have authority to resolve by majority vote grievances filed by Enrollees. The panel will include participants who were not involved in the previous decisions. A physician who was not previously involved will review the case when it involves a denial of services or treatment based on medical necessity. At least one	Enrollee Appeal Committee of the Board	Dental director or dental consultant.

	UnitedHealthcare	Wellmark Health Plan of Iowa	Delta Dental of Iowa
	practitioner in the same or similar specialty that typically manages the medical condition, procedure or treatment must be involved in the review at one level of the appeal process.		
Time for decision to be made	Grievance Committee Hearing should be held within 45 days of the receipt of the appeal letter. An additional 30 day extension is avialable due to a delay in obtaining documents necessary for the Grievance Committee to make a deterimination.	The Enrollee Appeal Committee of the Board will meet within 30 working days of receiving the appeal. The Enrollee Appeal Committee of the Board will issue a final decision and notify the Enrollee by letter within five business days of the meeting.	Within 30 days from the date of receipt of the second request.
Hearing notice information	The Enrollee shall be notified, at the time of the hearing, of the name and affiliation of the Enrollee Grievance Committee members. UHC shall not present any evidence without the Enrollee having been given the opportunity to be present. Each party may present his or her case as to why the decision rendered should be sustained or rejected. The Enrollee shall have the right upon written request to review all documents. The Enrollee may submit issues and comments in writing.	The Enrollee or someone acting on behalf of the enrollee may participate in the meeting of the Enrollee Appeal Committee of the Board. The Enrollee will receive a letter within five working days or receipt of appeal, acknowledging the receipt of the second level appeal and the date of the appeal meeting.	NA
Notification of decision	Final disposition letter detailing the reasoning of the decision, is mailed to the Enrollee within five business days after final decision by the Grievance Committee. The letter notifies the member of any further appeal rights they may have.	A written decision is sent to all parties.	A written decision is sent to all parties.
External Review	UHC shall not preclude the Enrollee from filing a complaint with the Department of	If the Enrollee has exhausted the Plan's appeal process regarding a	May appeal to the Iowa Insurance Commissioner.

	UnitedHealthcare	Wellmark Health Plan of Iowa	Delta Dental of Iowa
	Insurance nor shall it preclude the Department of Insurance from investigating a complaint persusant to its authority under section 4-6 of The HMO Act.	denial of benefits based on medical necessity, the Enrollee or the provider acting on behalf of the Enrollee may request a decision of the Wellmark's decision with the Iowa Insurance Commissioner. This request must be filed in writing no later than 60 days following Wellmark's decision.	
Other review	If a member is dissatisfied with the decision of the Member Grievance Committee, he or she may file a request for arbitration with UHC in writing within six months of the date of the decision. Arbitration shall be conducted in accordance with the Rules of the American Health Lawyers Association Alternative Dispute Resolution Service. The parties waive their right to jury trial, except for enforcement of the decision of the arbitrator.	NA	NA

Attachment 11 Delta Dental of Iowa

This document is replaced with Attachment 15.

A MILLIMAN GLOBAL FIRM

Milliman
Consultants and Actuaries

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St. Louis, MO 63102
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www.milliman.com

May 16, 2006

Ms. Shellie Goldman
Division of Medical Services
State of Iowa
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

RE: Actuarial Equivalency of New Plan

Dear Ms. Goldman:

Milliman was asked to review and determine if a proposed managed care plan was actuarially equivalent to the State's benchmark plan. This letter provides our response.

Background

Wellmark is in the planning stages of adding a managed care plan for the *hawk-i* program called Wellmark Health Plan of Iowa. Part of the review of this plan is to make sure the plan is actuarially equivalent to the State's benchmark plan.

Third Party Distribution

Milliman's work is prepared solely for the use and benefit of Iowa in accordance with its statutory and regulatory requirements. Milliman recognizes that materials it delivers to Iowa may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit and assumes no duty or liability to any third parties who receive Milliman's work in this fashion.

Reliances

In performing this analysis, we have relied on information provided by the State. We have reviewed this information for reasonableness but have not audited the data.

Limitations

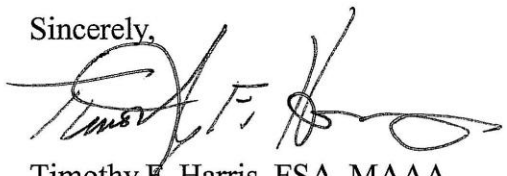
This report should not be distributed to any other party without our prior written consent. Any distribution of this report must be in its entirety.

Conclusion

We have reviewed the proposed hawk-i Blue Advantage plans for actuarial equivalency to the benchmark plan. Based on the material benefit differences, the Blue Advantage plans appear to be approximately 4% richer than the benchmark plan.

If you have any questions, please let us know.

Sincerely,



Timothy F. Harris, FSA, MAAA
Principal & Consulting Actuary

Attachment 13 *hawk-i* Health and Dental Plan Coverage Area
Enrollment Effective March 1, 2009

County	Plans
Adair	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Adams	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Allamakee	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Appanoose	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Audubon	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Benton	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Black Hawk	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Boone	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Bremer	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Buchanan	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Buena Vista	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Butler	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Calhoun	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Carroll	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Cass	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Cedar	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Cerro Gordo	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Cherokee	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Chickasaw	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Clarke	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Clay	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Clayton	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Clinton	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Crawford	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Dallas	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Davis	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Decatur	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Delaware	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Des Moines	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Dickinson	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Dubuque	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Emmet	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Fayette	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Floyd	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Franklin	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Fremont	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Greene	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Grundy	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Guthrie	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Hamilton	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Harding	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Harrison	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Henry	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Howard	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Humboldt	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Ida	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Iowa	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA

Jackson	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Jasper	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Jefferson	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Johnson	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Jones	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Keokuk	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Lee	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Linn	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Louisa	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Lucas	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Lyon	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Madison	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Mahaska	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Marion	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Marshall	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Mills	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Mitchell	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Monona	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Monroe	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Montgomery	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Muscatine	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
O'Brien	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Osceola	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Page	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Palo Alto	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Plymouth	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Pocahontas	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Polk	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Pottawattamie	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Poweshiek	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Ringgold	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Sac	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Scott	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Shelby	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Sioux	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Story	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Tama	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Taylor	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Union	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Van Buren	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Wapello	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Warren	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Washington	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Wayne	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Webster	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Winnebago	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Winneshiek	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Woodbury	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Worth	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA
Wright	Wellmark Health Plan of Iowa or United Healthcare, Delta Dental of IA

Attachment 14 hawk-i Health and Dental Plan Disaster Coverage Area

As of July 9, 2008:

Iowa counties declared a disaster by the Governor of Iowa (24):

Counties		
Adair	Howard	Palo Alto
Appanoose	Humboldt	Pocahontas
Audubon	Henry	Poweshiek
Carroll	Jackson	Ringgold
Cass	Jefferson	Shelby
Clarke	Lyon	Taylor
Grundy	Montgomery	Wayne
Guthrie	Monroe	Winnebago

Presidential Declaration of Disaster for Individual Assistance (62 counties):

Counties		
Adams	Floyd	Mahaska
Allamakee	Franklin	Mills
Benton	Fremont	Mitchell
Bremer	Greene	Monona
Black Hawk	Hardin	Muscatine
Boone	Hamilton	Page
Buchanan	Harrison	Polk
Butler	Hancock	Pottawattamie
Cedar	Jasper	Scott
Cerro Gordo	Johnson	Story
Chickasaw	Jones	Tama
Clayton	Iowa	Union
Clinton	Keokuk	Van Buren
Crawford	Kossuth	Wapello
Dallas	Lee	Washington
Davis	Linn	Warren
Dubuque	Louisa	Worth
Decatur	Lucas	Webster
Des Moines	Madison	Winneshiek
Delaware	Marion	Wright

Attachment 15 Outreach Results

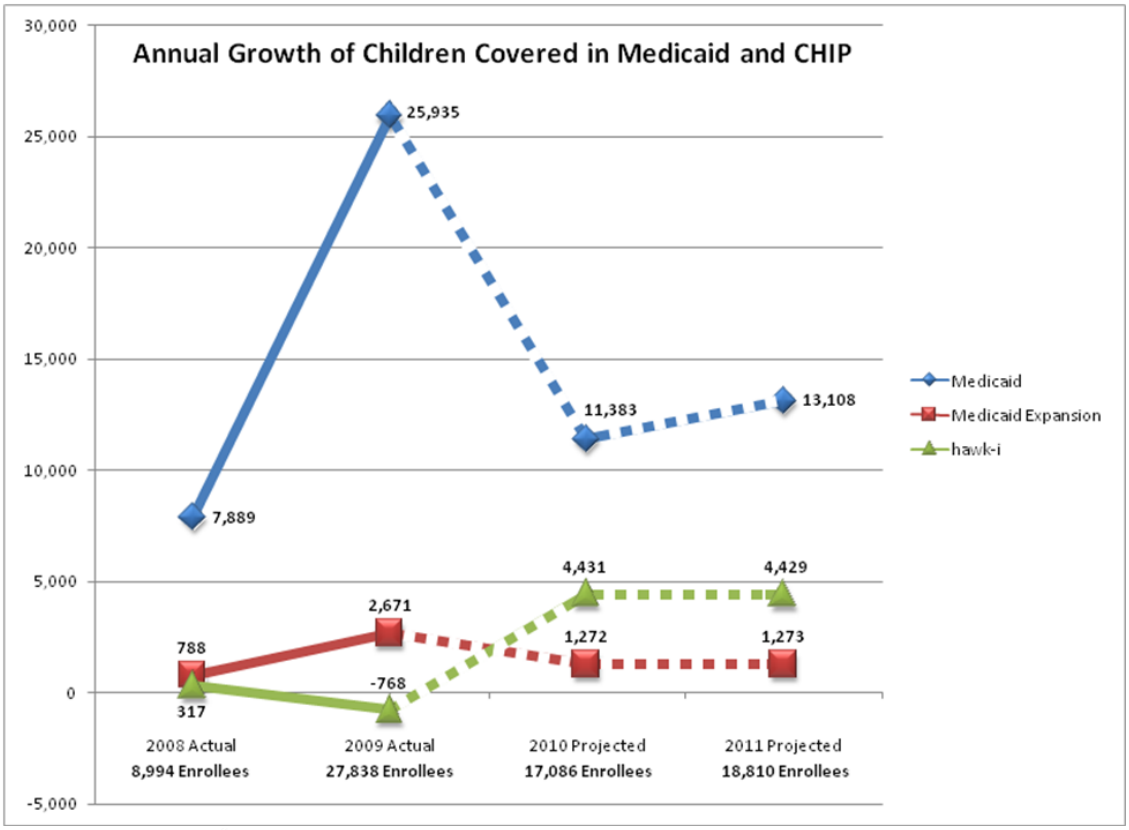
Iowa's CHIP Marketing Campaign Results from Jan 2008 – June 2009

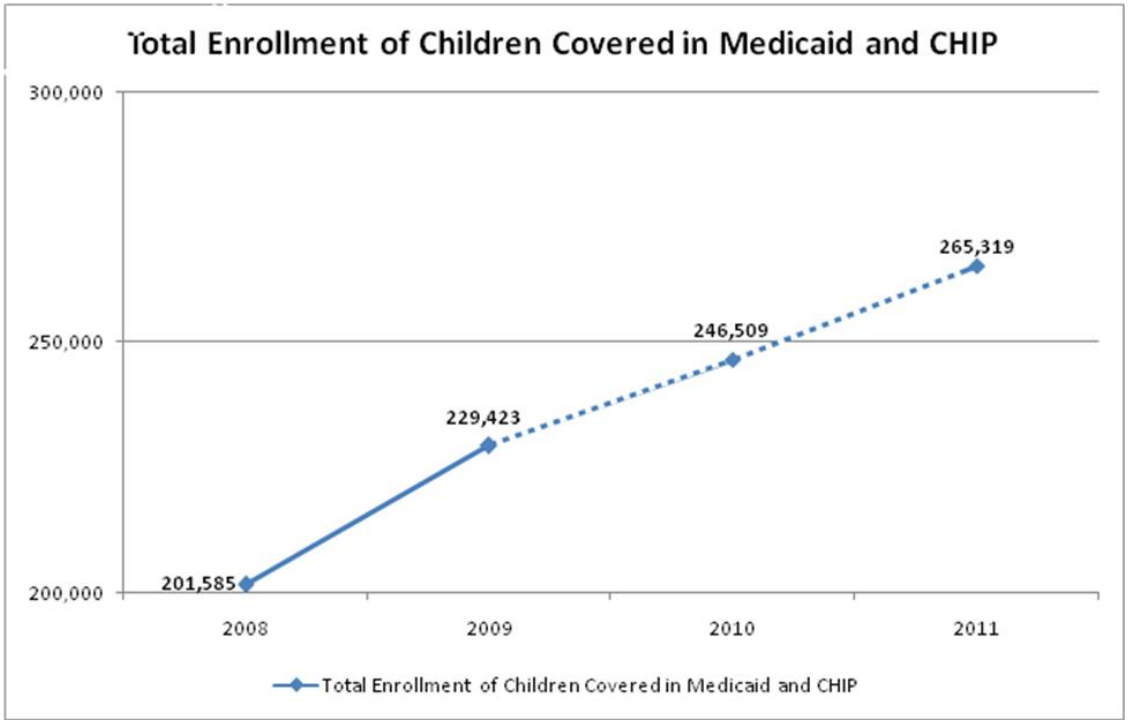
In January 2008, we began an extensive media campaign with ZLR Ignition. The focus was on families earning less than $40,000 per year, which is made up primarily headed by adults age 18-49. The campaign skewed slightly towards females and used a variety of stations and materials to cover the racial and ethnic aspects of our population.
The advertising vehicles included broadcast television, cable, radio, newspapers, gas pump toppers, bus transit and billboards.

- Broadcast television spots aired in all of Iowa's 99 counties.
- Cable television spots aired in 41 counties in 2008 and all 99 counties in 2009.
- Radio spots aired statewide for 24 weeks.
    - Radio extended the message to the hard-to-reach rural areas.
    - Radio advertisements were play specifically on African-American and Hispanic stations.
    - Total traffic sponsorship announcements aired to supplement the campaign.
- Newspaper advertisements included eight half-page ads, free standing insert in metro papers and a special section in 83 papers in 2008 and 75 papers in 2009 for "Cover the Uninsured Week". The section's articles included ***hawk-i*** *Helps Family Through Life-changing accident*, *Uninsured Kids at Greater Risk for Vaccine Preventable Diseases, Medicaid Provides Financial Lifeline, Tips to Raise Healthy Kids,* and *Study Finds Fewer Delays in Care, Better Overall Health for* ***hawk-i*** *covered Children*.
- Gas pump toppers posted statewide from March to July in 2008 and then received bonus posting from August to October. Some stations also posted free window clings.
- Transit ads were posted in Sioux City, Dubuque, Cedar Rapids, Waterloo, Clinton and Des Moines. The Des Moines posting specifically included the Iowa State Fair buses.
- Outdoor billboards were posted between February and April in both metro and rural areas. They were strategically placed in counties with income below $40,000 year and to reach a diverse population.
- In addition, we received $1,019,400 dollar in add values advertisement through 3,543 broadcast TV PSA's, 27,262 cable TV PSA's, 3,067 bonus radio spots, and 2,496 extra posting days on billboards in 2008. In 2009 the Department received $680,570 in added values advertisement through 2,511 broadcast TV public service announcements, 51,988 cable TV public service announcements, 448 bonus radio spots, and $109,258 worth of extra posting days on billboards.

ZLR Ignition held kick-off events in Des Moines and Cedar Rapids; promoted *Cover the Uninsured Week*; and began Cover the Kids Day, where more than 1,000 churches shared information about ***hawk-i*** with their congregations. In addition, they also created the new ***hawk-i*** logo, designed new letterhead and redesigned the brochure cover, bookmark and website.

The following chart show the enrollment changes since the media campaign began:





Iowa's Income Tax Return

For the 2008 tax form filed in 2009, the response rates of the 450,861 taxpayers who claimed at least one dependent child were:

- **13.7%** of families reported the absence of health care coverage;
- **62.7%** of families reported the presence of health care coverage; and
- **25.3%** of families did not report.

Department of Revenue cover letters with application brochures were sent to 57,450 potentially eligible households. Of these, 475 marked application brochures were returned and completed as follows:

- 140 applications were approved for ***hawk-i***
- 191 applications were referred to Medicaid
- 1 pending
- 143 were denied for:
    - Missing information was not received = 42 (29.5%)
    - Over income = 28 (19.5%)
    - Noncompliant with Medicaid = 47 (33%)
    - Over age 19 = 7 (4.75%)
    - Other health insurance = 6 (4%)
    - Child did not live with applicant = 4 (3%)
    - Home address not in Iowa = 2 (1.5%)
    - Immigration document invalid or missing = 7 (4.75%)

The results were that 471 (239 in ***hawk-i*** and 232 in Medicaid) previously uncovered children now have health care coverage. The costs for the project were $0.68 per household for materials and distribution. If you divide the cost by those children who now have health care coverage, the cost is $83.16 per applicant enrolled.

Attachment 16 Iowa *hawk-i* Dental Plan

IOWA DEPARTMENT OF HUMAN SERVICES

The Iowa hawk-i Dental Plan

Covered Benefits

3/1/2010

The Iowa *hawk-i* Dental Plan

If you are enrolled in this Plan, you are entitled to the benefits described below.

Cost Sharing: There are no copayments, deductibles or other cost sharing for this plan.

Annual Benefit Limit: There is a $1,000 benefit maximum per calendar year.

Exceptions to the $1,000 annual benefit maximum will be based on medical necessity and a prior authorization is required. For dental services to be paid above the $1,000 annual benefit maximum must allow a plan member to return to normal, pain and infection-free oral functioning. Typically this includes:

- Services related to the relief of significant pain or to eliminate acute infection;
- Services related to treat traumatic clinical conditions;
- Services that allow a patient to attain the basic human functions (e.g. eating, speech, etc.)
- Services that prevent a condition from seriously jeopardizing one's health/functioning or deteriorating in an imminent time frame to a more serious and costly dental problem.

Orthodontia Payment: Payment for medically necessary orthodontia services will be paid based on an approved treatment plan by the dental carrier and does not apply to the $1.000 benefit maximum.

Dental Providers: Please contact the dental carrier for information for a listing of approved dental providers. Delta Dental of Iowa: 1-866-544-0178 or http://www.deltadentalia.com/

hawk-i* Program**: For information on eligibility for the ***hawk-i program, call ***hawk-i*** customer services at 1-800-257-8563 or at www.hawk-i.org

Section 1 - Basic Services

The following is a list of services that are payable under the Iowa ***hawk-i*** Dental Plan. The list includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.

Diagnostic and Treatment Services
D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150 Comprehensive oral evaluation - Once per dentist in a three-year period when the recipient has not seen that dentist during the three years
D0180 Comprehensive periodontal evaluation - Once per dentist in a three-year period when the recipient has not seen that dentist during the three years
D0210 Intraoral – complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film D0240 Intraoral - occlusal film
D0270 Bitewing - single film - Children - 1 set every 12 months; 2 sets for “At High Risk” Children*
D0272 Bitewings - two films - Children - 1 set every 12 months; 2 sets for “At High Risk” Children*
D0274 Bitewings - four films - Children - 1 set every 12 months; 2 sets for “At High Risk” Children*
D0277 Vertical bitewings – 7 to 8 films – Children - 1 set every 12 months; 2 sets for “At High Risk” Children*
D0277 Vertical bitewings – 7 to 8 films – Children - 1 set every 12 months; 2 sets for “At High Risk” Children*
D0330 Panoramic film – 1 film every 60 (sixty) months
Preventive Services
D1120 Prophylaxis – Child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) – Limited to 2 every 12 months; additional application for “At High Risk” Children*
D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 18 - 2 every 12 months; additional applications for “At High Risk” Children*
D1206 Topical fluoride varnish - Less than age 19 - 2 in 12 months; additional application for “At High Risk” Children*
D1351 Sealant - per tooth - unrestored permanent molars - Less than age 18. 1 sealant per tooth every 36 months
D1510 Space maintainer – fixed – unilateral -- Limited to children under age 19
D1515 Space maintainer – fixed – bilateral -- Limited to children under age 19
D1520 Space maintainer - removable – unilateral -- Limited to children under age 19
D1525 Space maintainer - removable – bilateral -- Limited to children under age 19
D1550 Re-cementation of space maintainer -- Limited to children under age 19
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure

*** “**At Risk” Children –as documented by provider using caries risk assessment form

Section 2 - Intermediate Services

The following is a list of services that are payable under the Iowa ***hawk-i*** Dental Plan. The list includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.

Minor Restorative Services
D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent
D2330 Resin–based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces,
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown - primary tooth – Limited to 1 per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Limited to 1per tooth in 60 months
D2951 Pin retention - per tooth, in addition to restoration
Endodontic Services
D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy
Prosthodontic Services
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture - mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework

D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation
D5731 Reline complete mandibular denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture (chairside) - Limited to 1in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report
Oral Surgery
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions/quadrant
D7311 Alveoloplasty in conjunction with extractions-1-3 teeth or tooth spaces/quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-1-3 three teeth or tooth spaces/quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva

Section 3 - Major Services

The following is a list of services that are payable under the Iowa ***hawk-i*** Dental Plan. The list includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.

Major Restorative Services
D0160 Detailed and extensive oral evaluation - problem focused, by report
D2510 Inlay - metallic – one surface – An alternate benefit will be provided
D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided
D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided
D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 mon
D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic– Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months
D2794 Crown – titanium– Limited to 1 per tooth every 60 months
D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months
D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
Endodontic Services
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, rootresorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy
Periodontal Services
D4210 Gingivectomy or gingivoplasty – four or more teeth Limited to 1 every 36 months

D4211 Gingivectomy or gingivoplasty – one to three teeth
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
Prosthodontic Services
D5110 Complete denture - maxillary – Limited to 1 every 60 months
D5120 Complete denture - mandibular – Limited to 1 every 60 months
D5130 Immediate denture - maxillary – Limited to 1 every 60 months
D5140 Immediate denture - mandibular – Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, restsand teeth) – Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
D6530 Inlay – metallic – three or more surfaces 1 every 60 months
D6543 Onlay – metallic – three surfaces 1 every 60 months
D6544 Onlay – metallic – four or more surfaces 1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740 Crown - porcelain/ceramic -1 every 60 months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752 Crown - porcelain fused to noble metal - 1 every 60 months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months
D6782 Crown - 3/4 cast noble metal - 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
D6790 Crown - full cast high noble metal - 1 every 60 months
D6791 Crown - full cast predominately base metal - 1 every 60 months
D6792 Crown - full cast noble metal - 1 every 60 months
D6973 Core buildup for retainer, including any pins - 1 every 60 months
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

Section 4 - Orthodontic Coverage

Orthodontic procedures require prior approval. Orthodontia procedures will be approved for handicapping malocclusions only. A “handicapping” malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

- Impaired mastication,
- Dysfunction of the temporo-mandibular articulation,
- Susceptibility to periodontal disease,
- Susceptibility to dental caries, and
- Impaired speech due to malpositions of the teeth.

Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite. A Salzman Index score of 26 or greater will be used as criteria for “medically necessary” benefits.

Approval for treatment will be assessed in a manner consistent with “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J. A. Salzmann, DDS, American Journal of Orthodontics, October 1968.

A request for prior approval shall be accompanied by documentation as directed by the dental plan to substantiate medically necessary orthodontic benefits.

Post treatment records may be furnished upon request. Approval may be made a complete comprehensive case of active orthodontic treatment. Additional consideration for extenuated cases may be approved by the dental plan’s orthodontic consultant if found to be medically necessary.

<u>Minor Treatment To Control Harmful Habits</u>

D8210 Removable appliance therapy. Requires prior authorization.
D8220 Fixed appliance therapy. Requires prior authorization.

<u>Comprehensive Orthodontic Treatment Of Permanent Dentition/Transitional Dentition</u>

These procedures require prior authorization. Orthodontia procedures will be approved for documentation as directed by the dental plan to substantiate medically necessary orthodontic benefits.

Code Procedure Comment
D0140 Limited Oral Evaluation
D8070* Comprehensive treatment of transitional dentition
D8080* Construct and place maxillary or mandibular appliance with retainer & active treatment
D8210 Removable Appliance Therapy
D8220 Fixed Appliance Therapy
D8660 Pre-ortho visit/records
D8680 Orthodontic retention
D8690 Active treatment transfers . Use when recipient transfers from one provider to another.
D8999 Unspecified orthodontic procedure

Section 5 – Services Not Covered

The following is a list of services that are *not payable* under the Iowa ***hawk-i*** Dental Plan. ***Please Note:*** Even if a service is not specifically listed as an exclusion, it may not be covered under this plan. Contact the dental carrier if you are unsure a certain service is covered.

Services Not Covered
D0320 TMJ arthrogram
D0321 Other TMJ films
D0322 Tomographic survey
D0360 Cone Beam CT
D0362 Cone Beam multiple images 2 dim.
D0363 Cone Beam multiple images 3 dim.
D0416 Viral culture
D0418 Analysis of saliva example chemical or biological analysis of saliva for disagnostic purposes.
D0425 Caries test
D0431 Adjunctive pre-diagnostic test
D0475 Declassification procedure
D0476 Special stains for microorganisms
D0477 Special stains not for microorganisms
D0478 Immunohistochemical stains
D0479 Tissue in-situ-hybridization
D0481 Electron microscopy
D0482 Direct immunofluorescence
D0483 In-direct immunofluorescence
D0484 Consultation on slides prepared elsewhere
D0485 Consultation including preparation of slides
D0486 Brush biopsy sample
D1310 Nutritional counseling
D1320 Tobacco counseling
D1330 Oral Hygiene Instruction
D1555 Removal of fixed space maintainer
D7292 Surgical replacement screw retained
D7293 Surgical replacement w/surgical flap
D7294 Surgical replacement without the surgical flap
D7880 TMJ Appliance
D7899 TMJ Therapy
D7997 Appliance Removal
D7998 Intraoral placement of a fixation device
D2410 Gold Foil 1 surface
D2420 Gold Foil 2 surface
D2430 Gold Foil 3 surface
D2799 Provisional Crown
D2955 Post Removal
D2970 Temporary Crown
D2975 Coping
D3460 Endodontic Implant

D3470 Intentional reimplantation
D3910 Surgical procedure for isolation of tooth
D3950 Canal preparation
D4230 Anatomical crown exposure 4 or more teeth
D4231 Anatomical crown exposure 1-3 teeth
D4320 Splinting intracoronal
D4321 Splinting extracoronal
D5810 Complete denture upper (interim)
D5811 Complete denture lower (interim)
D5820 Partial denture upper (interim)
D5821 Partial denture lower (interim)
D5862 Precision Attachment
D5867 Replacement Precision Attachment
D5986 Fluoride Gel Carrier
D6057 Custom abutment
D6253 Provisional Pontic
D6920 Connector bar
D6940 Stress breaker
D6950 Precision Attachment
D6975 Coping – metal
D9210 Local Anesthesia not in conjunction with operative or surgical procedures
D9211 Regional Block Anesthesia
D9212 Trigeminal Division Block Anesthesia
D9215 Local Anesthesia
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
D9248 Non-intravenous conscious sedation
D9410 House / extended care facility call
D9420 Hospital Call
D9450 Case presentation
D9630 Other drugs and or medicaments
D9920 Behavior Management
D9941 Fabrication of athletic mouthguard
D9950 Occlusion analysis - mounted case
D9951 Occlusal adjustment - limited
D9952 Occlusal adjustment - complete
D9970 Enamel microabrasion
D9971 Odontoplasty 1-2 teeth
D9972 External bleaching - per arch
D9973 External bleaching - per tooth
D9974 Internal bleaching - per tooth
D0310 Sialography
D0472 Oral Pathology lab
D0473 Oral Pathology lab
D0474 Oral Pathology lab
D0480 Oral Pathology lab
D0502 Oral Pathology lab
D5911 Facial Moulage (sectional)
D5912 Facial Moulage (complete)

D5913 Nasal Prosthesis
D5914 Auricular Prosthesis
D5915 Orbital Prosthesis
D5916 Ocular Prosthesis
D5919 Facial Prosthesis
D5922 Nasal Septal Prosthesis
D5923 Ocular Prosthesis (interim)
D5924 Cranial Prosthesis
D5925 Facial Augmentation implant
D5926 Nasal Prosthesis (replacement)
D5927 Auricular Prosthesis (replacement)
D5928 Orbital Prosthesis (replacement)
D5929 Facial Prosthesis (replacement)
D5931 Obturator Prosthesis (surgical)
D5932 Obturator Prosthesis (definitive)
D5933 Obturator Prosthesis (modification)
D5934 Mandibular resection Prosthesis w/guide flange
D5935 Mandibular resection Prosthesis w/out guide flange
D5936 Obturator Prosthesis (interim)
D5937 Trismus Appliance
D5951 Feeding Aid
D5952 Speech Aid prosthesis (pediatric)
D5953 Speech Aid prosthesis (adult)
D5954 Palatal Augmentation Prosthesis
D5955 Palatal Lift Prosthesis (definitive)
D5958 Palatal Lift Prosthesis (interim)
D5959 Palatal Lift Prosthesis (modification)
D5960 Speech Aid Prosthesis (modification)
D5982 Surgical Stent
D5983 Radiation Carrier
D5984 Radiation Shield
D5985 Radiation Cone locator
D5987 Commissure Splint
D5988 Surgical Splint
D7285 Biopsy of oral tissue (hard)
D7286 Biopsy of oral tissue (soft)
D7410 Lesion up to 1.25 (benign)
D7411 Lesion greater than 1.25 (benign)
D7412 Complicated lesion (benign)
D7413 Lesion up to 1.25 (malignant)
D7414 Lesion greater than 1.25 (malignant)
D7415 Complicated lesion (malignant)
D7440 Lesion diameter up to 1.25 (malignant)
D7441 Lesion diameter greater than 1.25 (malignant)
D7460 Removal of Benign lesion up to 1.25
D7461 Removal of Benign lesion greater than 1.25
D7465 Destruction of lesion (by report)
D7490 Radical resection upper/lower

D7530 Removal of foreign body
D7540 Removal of reaction producing the foreign body
D7550 Partial Ostectomy
D7560 Maxillary Sinusotomy
D7610 Upper open reduction
D7620 Upper closed reduction
D7630 Lower open reduction (simple)
D7640 Lower closed reduction (simple)
D7650 Open reduction (simple)
D7660 Closed reduction (simple)
D7670 Alveolus closed reduction (simple)
D7671 Alveolus open reduction (simple)
D7680 Facial bones (simple)
D7710 Upper open reduction (compound)
D7720 Upper closed reduction (compound)
D7730 Lower open reduction (compound)
D7740 Lower closed reduction (compound)
D7750 Malar and/or zygomatic arch open red.(compound)
D7760 Malar and/or zygomatic arch closed red.(compound)
D7770 Alveolus open red.(compound - stabilization of teeth)
D7771 Alveolus closed red. (compound – stabilization of teeth)
D7780 Facial bones (compound)
D7810 TMJ open reduction
D7820 TMJ closed reduction
D7830 TMJ manipulation
D7840 Condylectomy
D7850 Surgical discectomoy
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-Arthroscopic
D7872 Arthroscopy with or without a biopsy
D7873 Arthoscopy surgical adhesions
D7874 Arthoscopy surgical disc
D7875 Arthoscopy surgical synovectomy
D7876 Arthoscopy surgical discectomy
D7877 Arthoscopy surgical debridement
D7911 Complicated sutures up to 5 cm.
D7912 Complicated sutures greater than 5 cm.
D7920 Skin graft
D7940 Osteoplasty deformities
D7941 Osteotomy lower rami
D7943 Osteotomy lower rami with bone graft
D7944 Osteotomy segmented

D7945 Osteotomy body of mandible
D7946 Lefort I upper total
D7947 Lefort I upper segmented
D7948 Lefort II or Lefort III without bone graft
D7949 Lefort II or Lefort III with bone graft
D7950 Bone graft - mandible or face
D7955 Repair of Maxillofacial soft or hard tissue
D7980 Sialolithotomy
D7981 Excision of salivary gland
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7990 Emergency tracheotomy
D7991 Coronoidectomy
D7995 Synthetic graft
D7996 Implant lower for augmentation purposes

Attachment 17 Training for Presumptive Eligibility

Slide 1

Welcome to Presumptive Eligibility for Children training for Qualified Entities.
The goal of this presentation is to discuss the qualifications and application process for Presumptive eligibility for Children. I will also discuss the roles and responsibilities of the Qualified Entity (QE) in the presumptive eligibility determination process. Individuals that wish to become a Qualified Entity must view this web-based training in its entirety before coming certified.

Slide 2- Agenda

Today we will be going over a number of topics-

- We will begin by defining Presumptive Eligibility for Children
- NEXT we will go over the Qualified Entity's roles and responsibilities in the Presumptive eligibility determination process.
- We will then discuss the Presumptive Eligibility Requirements
- As well as walk through the Application process &
- Using the Iowa Medicaid Portal Access system
- Lastly we will briefly discuss appeal rights, Record Retention, how to obtain paper application forms and IMPORTANT Contact Information

Slide 3- What is Presumptive Eligibility for Children?

The goal of presumptive eligibility is to provide a process that allows children to obtain Medicaid-covered services while a formal Medicaid eligibility determination is being made by the Department of Human Services (DHS). A qualified entity can "presume" that a child will be eligible for Medicaid based on a household's statements regarding their circumstances and income and grant temporary Medicaid eligibility during the presumptive period. During the presumptive eligibility period, the child is entitled to receive full Medicaid coverage.

- Presumptive eligibility is based on the household's statements on the application regarding circumstances and income.
- DHS may request additional information or documentation from the applicant to determine ongoing Iowa Medicaid coverage.

Slide 4- What is a Qualified Entity (QE)?

- A "qualified entity" (QE) is defined as individuals that are certified by the Department of Human Services (DHS) and are authorized to make presumptive eligibility determinations.
- QEs must be Medicaid providers or the employees of Medicaid providers
- ALL Authorized employees will be required to be certified individually.
- A potential QE shall apply to become certified to make Presumptive eligibility determinations.
- PRIOR to being certified EACH QE will be required to view this web-based training module.

Slide 5- Certification of QE

- ***hawk-i*** Outreach Coordinators will request authorization by contacting Melissa Ellis at the Iowa Department of Public Health. This will be done by providing Melissa with your registered Username to join the outreach group in IMPA.
- All others that are interested in certifying as a Qualified Entity will request authorization through the IME Provider Enrollment Unit by calling the number on the screen
- Once approved, the QE will be given access to Presumptive within the **Iowa Medicaid Portal Access (IMPA)** site.

Slide 6- Recertification of Qualified Entity (QE)

Qualified Entities who make presumptive eligibility determinations are required to be recertified annually. To be recertified, the QE must complete training electronically. Each authorized QE will be notified via email of the requirement to recertify 60 days in advance of their certification expiration date. This makes it necessary for each user have an individual email account to receive user-based notifications.

Each person authorized to make presumptive eligibility determinations will have a unique log-in and MUST NOT share their access authorization with others.

Slide 7- General Eligibility Requirements

Presumptive eligibility for children is based on the following criteria. The child must:

- be under age 19
    - This means the applicants age as of the 2nd day of the month the application is being received, for example:
        - *A child turns 19 on October 1st. They would be considered a child through the month of September, but not in October. A child turns 19 anytime from October 2nd through 31. They would be considered a child through the month of October.*
- Be an Iowa resident
- Be a citizen or qualified alien-undocumented children are not eligible
- Live in a household with gross income less than 300% of the **Federal Poverty Level (FPL**) based on the size of the household
- Not have received presumptive eligibility in past 12 months from the month the application is received by the QE.

- **Note:** For emancipated minors – Do not count income or household members that are parents, stepparents, or siblings. Only count the emancipated minor's spouse and any children of the emancipated minor.

- An emancipated minor is defined as a person who is or has been married and the marriage has not been annulled or a person who the courts have released from the control of parents.

Slide 8-Presumptive Eligibility Health Care Application & QE Role

A person requesting presumptive eligibility for a child must complete a *Presumptive Health Care Coverage for Children* Application and submit it to a Qualified Entity.

The information provided must be entered into the online application exactly as documented. The information provided is self-declared and is not yet verified.

With that in mind, please note that **all** presumptive applications are referred to DHS for an ongoing Medicaid eligibility determination for the child. At that time the information provided will be verified as necessary.

Slide 9- Duties of the QE

The Qualified Entity is required to:

- Date stamp the application with the date that it is **received**
- Clarify information on the application, if necessary.
  - For instance- if the writing is not legible or important information is missing (such as the child's social security number- and he/she is not exempt from the ss# requirement) that information must be noted and clarified before the application can be entered into the PE system.
- The QE must also inform the household that **All** presumptive applications are referred to DHS for an ongoing Medicaid or *hawk-i* eligibility determination for the children. During the formal Medicaid eligibility determination, DHS will verify income, citizenship, alien status, identity, and other information as necessary.
- The QE will then enter information from the application into the Iowa Medicaid Provider Access Presumptive eligibility application system within *3 business days*.
  - Information must be entered EXACTLY as it is written on the signed application.
  - Data entries made by the QE are used to electronically calculate presumptive eligibility. All information on the application is self-declared by the household; therefore-is not verified.
- Provide a **Notice of Decision (NOD)** to the applicant within 2 *business days* of the date stamped on the application. The NOD reflects the eligibility decision based on the information entered from the application.
- Maintain documentation to support the presumptive eligibility decision. This may include, but is not limited to the application, clarification of any information provided by the household, and a copy of the NOD.
  - We will discuss the record retention requirements later in this training.

Slide 10- IMPA & link

After becoming certified as a Qualified Entity you will be granted access to the Iowa Medicaid Portal Access (IMPA) site. Here you will be able to submit applications, edit applications that have not yet been submitted to DHS, and review applications previously submitted by you.

IMPA manages many different types of tools and applications. Signing up for IMPA is as simple as entering your Name, telephone number, email address and setting up a password. There are no restrictions on who may sign-up to view the IMPA portal. Once

registered, however, you must request access to each feature or tool. QE's for example will need to request access to the Presumptive Eligibility application.

The link on the screen will take you to the IMPA Home page.

Slide 11- IMPA Home Page

The IMPA homepage displays the latest in Helpful Hints, Medicaid News, and lists the features that the portal offers. On the bottom left you will find links to both the English and Spanish versions of the Presumptive Eligibility Application. You may register a New Account by clicking the link at the top of the page. You may sign-in to an existing account OR Reset your account if you forget your user name or password.

Slide 12- Login

Once you have been registered for IMPA and have been granted access to the Presumptive Eligibility portion of the IMPA system – you will log in to the site.

- Towards the bottom of the homepage you will find a link to download and print the Presumptive application in either English or Spanish for the applicant to complete and sign PRIOR to you as the QE entering the information into the electronic application.
- To begin entering a new application, choose "File" at the top of the screen and click "New Presumptive-Infant and Children".

If you are already an IMPA user-the same username can be utilized for all IMPA applications, you will simply request access to the Presumptive application through IMPAsupport@dhs.state.ia.us.

After logging on to the IMPA- Presumptive Portal you will have the capability of entering data into the online Presumptive eligibility application. As the QE you will enter the information from the presumptive application that was completed by the household into the online system. Make sure that the information is entered exactly as it appears on the application signed by the applicant.

Slide 13-

- Enter the basic information for the applicant.
    - APPLICANT is the name of the parent, guardian, care taker or adult completing the application on behalf of the child. The household member who completed the application should be the head-of household.
    - Choose language- English OR Spanish,
    - NEXT – Enter the date-this may be done manually on through the calendar icon- then choose the date that the application was ACTUAL LY received… not necessarily today's date.
    - **Remember** that the online application MUST BE completed within 3 business days of the date that the paper application was received & date stamped. The Notice of Decision must be provided no later than two days after the online application is completed.

Slide 14-

Enter County, First Name, Middle Initial, Last Name& Suffix (if applicable)

Slide 15-
Enter Date Of Birth (DOB) in 8 digit mm/dd/yyyy or use the calendar icon & choose the DOB.

Slide 16-
Use the calendar icon by scrolling through months by clicking the forward or backward arrow on the calendar.

- You may click on the Month/Year Header to broaden your search for years.
- You may scroll through years by clicking the forward or backward arrow on the calendar.

Once you have located the YEAR of birth – click the year on the calendar to choose the month of birth. You will notice the Month and Year of birth on the header of the calendar. Choose the day of birth. The date of birth field will display the DOB in Month/Day/Year format.

Slide 17-
Enter the telephone number of the applicant as provided on the application.

Slide 18-
A social security number is required on the application for **all Children** for whom presumptive eligibility is being requested. This number MUST be entered **before** the application can be submitted to DHS and before presumptive eligibility can be determined in the IMPA System.

There are two exceptions to this requirement including:

- Children (mostly infants) who have applied for a social security number but have not yet received the social security number. In this case you will use the drop down box to indicate "applied for".
- Those who don't have a social security number due to religious objection are not required to provide a SSN. In this case you will mark "Not Required Due to Religion".

Again, the social security number requirement ONLY applies to the children for whom Presumptive Eligibility is being requested for. The application will not be denied if the social security number is not available for a parent, caretaker or other household member that is not applying for Presumptive coverage. In all other cases the application must include a valid social security number for the child before it can be submitted via the IMPA-Presumptive system for Presumptive eligibility determination. If the social security number is not on the application and the household has not given one of the two valid reasons for exemption – As the QE you must contact the applicant/household and advise them that the SSN must be supplied before the application can be submitted for eligibility consideration. You may fill out the rest of the application online and save the application until the household provides the necessary information.

Slide 19-
Enter applicants Address, City, State & Zip code

Slide 20-
If the mailing address is the same as the home address listed above check the box “to use Home Address”.

Slide 21-
If the mailing address is different than the home address, enter the address here.
Once you have clicked “Save” you will be prompted to complete additional information about the applicant.

Slide 22-
Next click View Household Members to enter the demographic details for each household member.

Slide 23-
Check “YES” if the applicant is currently enrolled in Medicaid , *hawk-I or* other insurance

Slide 24-
- **Mark YES or NO** to indicate whether THIS individual is applying for Medicaid eligibility. Remember that adults over the age of 19 will not be approved for Presumptive eligibility for Children. If you select “yes” for an adult over the age of 19 the system will deny eligibility from Presumptive Medicaid but will pass the adult(s) to DHS as an applicant for on-going Medicaid.
- **Enter the first and last name of each person listed on the application**
- Select the **gender** of the individual

Slide 25-
- Select the **RELATIONSHIP of the individual to the Head of Household.**
    - PARENT is defined as a biological, adoptive or step-parent.
    - A caretaker is a grandparent, other relative or other adult such as a guardian who is caring for the child or children.
        - **Do not count caretakers or their income when determining presumptive eligibility for the children. Caretakers are not considered in the household size or income.**
    - *It is extremely important that the relationship is entered correctly in order for the presumptive application to be properly determined the QE.*

Slide 26-
Enter the date of birth. Use the drop-down calendar to change the date.
- Select the **State** of Residence
- Select **Race/Ethnicity; This is optional on the application and may be left blank**
- Select **“YES” or “NO”** to indicate whether the individual is a **US resident**
- If the individual is an **alien**, Select the type of alien status.
- If the individual is **Disabled click “YES”,** if no- leave blank.

- If the individual is currently receiving **Disability** benefits indicate which State the benefits are coming from.
- If the individual has **income, select "YES"**
    - NOTE: Adult relatives, caretakers and other adults that are not the child's biological, adoptive or step-parents are NOT included in the household income. If the individual is exempt from the household size or income & income is entered, the system will not use the amount to calculate the household size or income. ***AGAIN it is extremely important that the relationship status is marked properly.***

Slide 27-

- Select "SAVE" when all information on the page has been entered & accuracy of the information entered has been verified.

If you click "YES" to income- the household income box will appear at the bottom of the screen. Click on "NEW" to enter the income information. Click "INSERT" to add income & source. Click "Cancel" to choose not to remove that source of income.
REMEMBER GROSS INCOME is amount BEFORE deductions!
Again, Click "SAVE" to continue

Slide 28-

Click ***"Add Household Member"*** to add additional household members. Each time you click "Add Household Member" you will see the member added to the list of "Household Members" on the top of the page.

- When determining household size, count the child, the child's siblings (age 19 & under), parents (biological or adoptive), stepparents, and the child's children. Other relatives (ex. Grandparent, aunt, uncle) or other caretakers are not included in the household size or income. You must indicate "caretaker" in the online application so that the caretaker is not used in the income/household size calculation.
    - For emancipated minors – Do not count income or household members that are parents, stepparents, or siblings. Only count the emancipated minor's and any children of the emancipated minor, if any.
    - An emancipated minor is defined as a person who is or has been married and the marriage has not been annulled or a person who the courts have released from the control of parents.

The total Household income will be displayed at the top of the screen. The household members and income will update each time you have entered and saved a household member's information.

Slide 29-

Enter information about each additional household member. Make sure that you indicate "CHILD" for the child/children that are applying for presumptive eligibility AND mark "YES" in the box titled "APPLYING FOR"

Slide 30-
If you need to make changes at any point – correct the information click "EDIT" next to the name of the household member at the top of the page. Click "UPDATE" – to save the added information.

Slide 31-
Click "Edit" to view information for each household member and VERIFY that ALL information has been entered correctly for ALL household members. Check spelling, SSN, income, address, DOB, relationship, etc. Once the application is submitted this information CANNOT be changed. Incorrect information may cause the application to be approved or denied inappropriately.
Once it is submitted, it can't be changed and the formal eligibility decision will be made by DHS.
Click "SEND TO DHS" to submit the application.

Slide 32-
A notification box will appear to confirm that you are ready to submit. Click OK to submit. Click Cancel to edit the application.

Slide 33-
Once submitted you may click "Open NOD" to view and print the Notice of Decision. The notice of decision will list the individuals that indicated they were applying for Medicaid on the application. The Presumptive eligibility decision will also be displayed on the NOD.

Slide 34-
**PRINT the Notice of Decision & give or mail the NOD to Applicant within 2 business days.

Slide 35-
- You may review pending or previously submitted applications by clicking the "Review" link at the top of the screen and then clicking "Existing Presumptive".
- You may view by typing in the first and/or last name or scrolling down the page.
- You may also sort by "PENDING" and "COMPLETED".
- Choose "Select" to view or edit application.
- You may delete applications – PRIOR TO sending to DHS
    - The application may not be deleted once it has been submitted or marked as complete by the QE by clicking "Send to DHS"

Slide 36-
Click "Manage" & "My Account" to modify or view your account settings- including:
Update Information, Update Password, Update Security Questions, VIEW Associated Groups, VIEW Associated Tax Entities, VIEW Associated Applications.

Slide 37- What Is Next?
- If eligible, coverage begins on the day the decision is made.

- The DHS/IME eligibility system takes approximately 1-2 days to show the new Presumptive Eligibility. In the meantime the individual must present the written notice to medical providers to show proof of eligibility.
- Medicaid cards are NOT issued to presumptively eligible individuals.
- The Qualified Entity (QE) must notify the applicant in writing within 2 days whether the child qualifies for Presumptive Health Care Coverage.
- The IMPA system will electronically transmit the Presumptive application to DHS for review of ongoing Medicaid eligibility. If Medicaid coverage is denied, the application will be forwarded to *hawk-i* for an eligibility determination.

Slide 38- Time Period to Receive Presumptive Eligibility

It is important for the Qualified Entity AND applicant to understand that unlike regular Medicaid which is granted on a monthly basis, Presumptive eligibility may end at any time during the month.

A child may receive Medicaid coverage under presumptive eligibility until one of the following occurs:

- The day Medicaid eligibility is established, OR
- The last day of the month when *hawk-i* eligibility is established, OR
- The day Medicaid eligibility is denied if no referral to *hawk-i* is made, OR
- The day *hawk-i* eligibility is denied, OR
- The last day of the next calendar month if:
  - The application is withdrawn, or
  - The application is pended on the Automated Benefit Calculation (ABC) system

Slide 39- Appeal Rights

- There are no appeal rights for people who apply for presumptive eligibility because a presumptive period is temporary and not considered a formal Medicaid eligibility determination.
- Appeal rights are given with formal or ongoing Medicaid eligibility determinations.

Slide 40- Record Retention

- A QE shall keep records of the presumptive eligibility determinations for a period of three years for audit purposes.

Slide 41- Obtaining Forms

- A qualified entity will need a supply of the *Application for Presumptive Health Care Coverage for Children*.
  - The *Presumptive Eligibility Health Care Application* will be available electronically in English and Spanish for printing. Ordering forms is not an option.
- The applications are located on the IMPA homepage.

Slide 42- Contact Information

- To certify or recertify as a Qualified Entity contact Melissa Ellis at the IDPH if you are a *hawk-i* Outreach Coordinator, all others will contact the Iowa Medicaid Provider Enrollment unit at by e-mail at IMPAsupport@dhs.state.ia.us or call us @ 800-338-7909 (Option 2) or locally at 515-256-4609.
- For technical issues please contact the IME Provider Services unit by emailing the email address on the screen.
- For questions related to the presumptive eligibility criteria or application please contact your local DHS office. A directory of all local DHS offices can be found online at www.dhs.state.ia.us

Slide 43- Conclusion

You have now completed the REQUIRED Presumptive Eligibility for Children training for Qualified Entities.

hawk-i Outreach Coordinators must complete the "Confirmation of Completion" form that was sent to you along with the link to this presentation. The completed and signed form must be faxed to Melissa Ellis at the fax number provided on the form. This form must be submitted before access to the IMPA-Presumptive portal can be granted.