Table of Contents

State/Territory Name: IA

State Plan Amendment (SPA) #: 17-0009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 601 East 12th Street, Suite 355 Kansas City, Missouri 64106



Division of Medicaid and Children's Health Operations

October 20, 2017

Jerry R. Foxhoven Director Department of Human Services Hoover State Office Building 1305 East Walnut, 5th Floor Des Moines, IA 50319-0114

Dear Mr. Foxhoven:

On September 20, 2017, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) Transmittal #17-0009. This SPA eliminates the dental co-pay for adults due to the expansion of the state's Dental Wellness Plan.

SPA #17-009 was approved October 19, 2017, with an effective date of July 1, 2017, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Iowa State Plan.

If you have any questions regarding this amendment, please contact Sandra Levels, at (816) 426-5925.

Sincerely,

James G. Scott Associate Regional Administrator for Medicaid and Children's Health Operations

Enclosure

cc:

Mikki Stier, DHS, IME Julie Lovelady, IME Alisa Horn, IME

TO STAGRITURE A SER DIAMIAM AM ADDIMATE	1. TRANSMITTAL NUMBER 2. STATE			
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1 7 — 0 0 9 IOWA			
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)			
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE			
CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 1, 2017			
5. TYPE OF PLAN MATERIAL (Check One)				
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONS	SIDERED AS NEW PLAN			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME	NDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION Section 1916 of the ACT and 42 CFR 447.52 *	7. FEDERAL BUDGET IMPACT a. FFY 2017 \$ (3,844,258.00) b. FFY 2018 \$ (15,273,706.00)			
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	b. FFY 2018 \$ (15,273,706.00) 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION	NI		
G2a	OR ATTACHMENT (If Applicable) G2a	•		
0. SUBJECT OF AMENDMENT				
SPA is being updated to reflect changes to the will be eliminated for Medicaid adult enrolled modified Dental Wellness Plan. 1. GOVERNOR'S REVIEW (Check One) GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	OTHER, AS SPECIFIED			
2. SIGNATURE OF STATE AGENCY OFFICIAL	16. RETURN TO			
	Jerry R. Foxhoven			
3. TYPED NAME Towns B. Fourbasson	DIRECTOR			
Jerry R. Foxhoven	DEPARTMENT OF HUMAN SERVICES 1305 EAST WALNUT 5TH FLOOR			
4. TITLE DIRECTOR	DES MOINES IA 50319-0114			
5. DATE SUBMITTED 9-18-17				
FOR REGIONAL O	FFICE USE ONLY	NAMAN.		
7. DATE RECEIVED	18. DATE APPROVED			
September 18, 2017 PLAN APPROVED - O	October 19, 2017			
9. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL			
July 1, 2017	//s//			
1. TYPED NAME	22 TITLE			
I. LIPED NAME		11.00		
James G. Scott	Associate Regional Administrator			
James G. Scott	Associate Regional Administrator for Medicaid and Children's Health Operations			
James G. Scott	Associate Regional Administrator			
James G. Scott 3. REMARKS	Associate Regional Administrator			
James G. Scott 3. REMARKS	Associate Regional Administrator			
James G. Scott 23. REMARKS	Associate Regional Administrator			
James G. Scott 23. REMARKS	Associate Regional Administrator			



State Na	nme:	Iowa						Copayment charged for each covered drug dispensed. The cost to the State is determined without regard to federal financial participation in the Medicaid program or any rebates received. Any brand-name drug not subject to prior approval based on non-preferred status on the preferred drug list published by the Department pursuant to Iowa Code Section 249A.20A shall be treated as a preferred brand-name drug.			
Transmi	ittal 1	Number: <u>IA</u> -	- 17 - 0009				MATERIAL SON	Exp	iration date	e: 10/31/2014	4
Cost S	har	ing Amoun	ts - Categorica	ılly Needy	Individu	als				G2a	
1916 1916A 42 CFR	447.	52 through 54									
			ing to <u>all</u> categoric the Same Cost S				•	tions for Coverage) individu	als.	Yes]
		Service or Iter	m Amount	Dollars or Percentage	1	t		Explanation			_
+				\$	Other					X	-
Ser	Ser	vice or Item:		d brand name	drugs		s service (or item varies.	Ren)
			Incomes Less than or Equal to		Dollars or Percentage	Ţ	J nit	Explanation	on		
	+	0% FPL	50% FPL	0.00	\$	Prescri	ption				,
	+	50% FPL	No upper limit	1.00	\$	Prescri	ption	dispensed. The cost to the without regard to federal fi participation in the Medica rebates received. Any bran subject to prior approval by preferred status on the pref published by the Departme Iowa Code Section 249A.2	State is det nancial id progran d-name dr ased on no erred drug ant pursuan 0A shall b	n or any ug not n-list tto	(
								ate is \$25.01 to \$50	Rer	nove Service or Item	3
	Indi		ne ranges by which	h the cost shar			s service o	or item varies.			_
			Incomes Less than or Equal to	Amount	Dollars or Percentage		J nit	Explanation	on		K K
	+	0% FPL	50% FPL	0.00	\$	Prescri	ption			X	,

Transmittal Number: IA-17-0009 Supersedes Transmittal Number: IA-16-002 Approved Effective Date: July 1, 2017
Approval Date: October 19, 2017 Page 1 of 6



	Incomes	Incomes Less		Dollars or				Τ
	Greater than	than or Equal to		Percentage	Unit	Explanation		
+	50% FPL	No upper limit	2.00	\$	Prescription	Copayment charged for each dispensed. The cost to the subject to prior approval bar preferred status on the preferred by the Departme Iowa Code Section 249A.2 as a preferred brand-name of the dispense of the preferred brand-name of the preferred brand-na	State is determined nancial id program or any d-name drug not used on non-erred drug list nt pursuant to 0A shall be treated	
Ser	vice or Item:	Non-preferred bran	ıd-name drug	s for which	the cost to the s	tate is \$50.01 or more	Remove Se or Item	
ndi		ne ranges by which	n the cost shar		for this service	or item varies.		_
	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanatio	on	
+	0% FPL	50% FPL	0.00	\$	Prescription			
+	50% FPL	No upper limit	3.00	\$	Prescription	Copayment charged for each covered drug dispensed. The cost to the State is determined without regard to federal financial participation in the Medicaid program or any rebates received. Any brand-name drug not subject to prior approval based on non-preferred status on the preferred drug list published by the Department pursuant to Iowa Code Section 249A.20A shall be treated as a preferred brand-name drug.		
Ser	vice or Item:	Chiropractor servic	es				Remove Se or Item	
	cate the incom	ne ranges by which	n the cost shar	ring amount	for this service	or item varies.		
ndi				Dollars or				-
ndi	Incomes Greater than	Incomes Less than or Equal to	Amount	Percentage	Unit	Explanation	on	
ndi		Incomes Less than or Equal to 50% FPL	Amount 0.00	Percentage \$	Unit Day	Explanation	on	1
+	Greater than	than or Equal to		\$		Explanation Copayment charged for the rendered on a given date.		+
+	Greater than 0% FPL 50% FPL	than or Equal to 50% FPL	0.00	\$	Day	Copayment charged for the		rv
+	Greater than 0% FPL 50% FPL vice or Item: Pecate the incom	than or Equal to 50% FPL No upper limit Physical therapy the ranges by which	1.00	\$ sring amount	Day	Copayment charged for the rendered on a given date.	e total services Remove Se	rv
+	Greater than 0% FPL 50% FPL vice or Item: P cate the incomes Incomes Greater than	than or Equal to 50% FPL No upper limit Physical therapy	1.00	\$	Day	Copayment charged for the rendered on a given date.	Remove Se or Item	rv
+	Greater than 0% FPL 50% FPL vice or Item: P cate the incom Incomes	than or Equal to 50% FPL No upper limit Physical therapy the ranges by which Incomes Less	1.00 1.00 Amount	\$ sring amount Dollars or Percentage	Day Day for this service	Copayment charged for the rendered on a given date.	Remove Se or Item	rv

Transmittal Number: IA-17-0009 Supersedes Transmittal Number: IA-16-002 Approved Effective Date: July 1, 2017

Approval Date: October 19, 2017



	Incomes eater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation		
	FPL	50% FPL	0.00		Day	Laplanation		_
► 50%	% FPL	No upper limit	1.00		Day	Copayment charged for the to rendered on a given date.	otal services	_
ervice	or Item: A	mbulance service	S				Remove Se or Iten	
ndicate	the incom	e ranges by which	the cost sha	ring amoun	t for this servic	e or item varies.		
- 1	Incomes reater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation		
F 0%	FPL	50% FPL	0.00	\$	Day			
5 0%	% FPL	No upper limit	2.00	\$	Day	Copayment charged for the to rendered on a given date.	otal services	_
		audiologist service		ring amoun	t for this service	e or item varies.	Remove Se or Iten	
I	Incomes	Incomes Less than or Equal to	Amount	Dollars or Percentage		Explanation		_
F 0%	FPL	50% FPL	0.00	\$	Day			
► 50%	% FPL	No upper limit	2.00	\$	Day	Copayment charged for the to rendered on a given date.	otal services	_
	<u> </u>	learing aid dealer					Remove Se or Item	
I	Incomes	e ranges by which Incomes Less than or Equal to	Amount	Dollars or Percentage	t for this servic	e or item varies. Explanation		_
	FPL	50% FPL	0.00		Day			_
→ 50%	% FPL	No upper limit	2.00	\$	Day	Copayment charged for the to rendered on a given date.	otal services	_
	<u> </u>	fedical equipment	<u> </u>		<u> </u>		Remove Se or Iten	
	Incomes reater than	Incomes Less than or Equal to	Amount	Dollars or Percentage		Explanation		_
Gr	FPL	50% FPL	0.00	\$	Day			
Gr		<u> </u>	2.00			Copayment charged for the to	otal services	_
Gr • 0%	% FPL	No upper limit	2.00	\$	Day	rendered on a given date.		_

Transmittal Number: IA-17-0009 Supersedes Transmittal Number: IA-16-002 Approved Effective Date: July 1, 2017
Approval Date: October 19, 2017 Page 3 of 6



	Incomes	Incomes Less		Dollars or				
	Greater than	than or Equal to	Amount	Percentage	Unit	Explanation	าท	
+	0% FPL	50% FPL	0.00		Day	Emplantic	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	X
+	50% FPL	No upper limit	2.00		Day	Copayment charged for the	total services	<u> </u>
					[-3]	rendered on a given date.		
Serv	rice or Item:	Optometrist service	es				Remove Ser or Item	
ndic	cate the incom	e ranges by which	n the cost sha		for this service	or item varies.		
	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	on	
+	0% FPL	50% FPL	0.00		Day)
+	50% FPL	No upper limit	2.00		Day	Copayment charged for the rendered on a given date.	total services)
Serv	rice or Item:	Orthopedic shoes					Remove Ser	
	_	ne ranges by which	n the cost sha	ring amoun	t for this service	or item varies.	Of Item	<u></u>
	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	on	
+	0% FPL	50% FPL	0.00	\$	Day	Explanate	Л	
+	50% FPL	No upper limit	2.00		Day	Copayment charged for the total services rendered on a given date.)
- 1						irendered on a given date.		_ _
						rendered on a given date.	Domovo Sor	
	rice or Item:	sychologist servic	ees			rendered on a given date.	Remove Ser	rvio
Serv		sychologist service ranges by which		ring amoun	for this service			rvic
Serv	cate the incom	ne ranges by which	n the cost sha	Dollars or		or item varies.	or Item	rvic
Serv	cate the incom	ne ranges by which		Dollars or Percentage	Unit		or Item	rvic
Serv ndic	Incomes Greater than	e ranges by which Incomes Less than or Equal to	n the cost sha	Dollars or Percentage		or item varies. Explanation Copayment charged for the	or Item	rvio
Serv	Incomes Greater than 0% FPL 50% FPL	Incomes Less than or Equal to 50% FPL	Amount 0.00 2.00	Dollars or Percentage	Unit Day	or item varies. Explanation	or Item on total services Remove Ser	Trvio
Servindic + Servindic	Incomes Greater than 0% FPL 50% FPL	Incomes Less than or Equal to 50% FPL No upper limit	Amount 0.00 2.00 acy services	Dollars or Percentage \$	Unit Day Day	or item varies. Explanation Copayment charged for the rendered on a given date.	or Item	Trvio
Servindic + Servindic	Incomes Greater than 0% FPL 50% FPL rice or Item: Recate the incomes	Incomes Less than or Equal to 50% FPL No upper limit Rehabilitation ager are ranges by which	Amount 0.00 2.00 acy services the cost sha	Dollars or Percentage \$ sring amount Dollars or	Unit Day Day	or item varies. Explanation Copayment charged for the rendered on a given date. or item varies.	or Item on total services Remove Ser or Item	rvic
Servindio Servindio	Incomes Greater than 0% FPL 50% FPL rice or Item:	Incomes Less than or Equal to 50% FPL No upper limit Rehabilitation ager are ranges by which	Amount 0.00 2.00 acy services	Dollars or Percentage \$ ring amount Dollars or Percentage	Unit Day Day for this service	or item varies. Explanation Copayment charged for the rendered on a given date.	or Item on total services Remove Ser or Item	rvic
Servindic	Incomes Greater than 0% FPL 50% FPL rice or Item: Recate the incomes Incomes Greater than	Incomes Less than or Equal to 50% FPL No upper limit Chabilitation ager are ranges by which Incomes Less than or Equal to	Amount 0.00 2.00 2.00 acy services a the cost sha	Dollars or Percentage \$ ring amount Dollars or Percentage \$	Unit Day Day t for this service Unit	or item varies. Explanation Copayment charged for the rendered on a given date. or item varies.	or Item on total services Remove Ser or Item	rvic
Servindic	Incomes Greater than 0% FPL 50% FPL rice or Item: Reate the incomes Incomes Greater than 0% FPL	Incomes Less than or Equal to 50% FPL No upper limit Rehabilitation ager are ranges by which Incomes Less than or Equal to 50% FPL No upper limit	Amount 0.00 2.00 0.00 0.00 0.00 0.00	Dollars or Percentage \$ ring amount Dollars or Percentage \$	Unit Day Day t for this service Unit Day	or item varies. Explanation Copayment charged for the rendered on a given date. or item varies. Explanation Copayment charged for the	or Item on total services Remove Ser or Item	rvice

Transmittal Number: IA-17-0009 Supersedes Transmittal Number: IA-16-002 Approved Effective Date: July 1, 2017
Approval Date: October 19, 2017 Page 4 of 6



	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	on	
+	0% FPL	50% FPL	0.00	\$	Day	-		
+	50% FPL	No upper limit	3.00	\$	Day	Copayment charged for the rendered on a given date	total services	
Serv	vice or Item:	ervices rendered i	in a physician	(MD/DO)	office visit		Remove Se or Item	
ndi	cate the incom	e ranges by which	h the cost sha	ring amoun	t for this service	e or item varies.		
		Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	on	
+	0% FPL	50% FPL	0.00	\$	Day			
+	50% FPL	No upper limit	3.00	\$	Day	Copayment charged for the rendered on a given date.	total services	
Serv	vice or Item:	Medicare Part B cr	ossover clain	าร			Remove Se or Item	
ndi	cate the incom	e ranges by which	h the cost sha	ring amoun	t for this service	e or item varies.		
		Incomes Less than or Equal to		Dollars or Percentage	Unit	Explanation	on	
+	0%	50% FPL	0.00	\$	Other			
+	50% FPL	No upper limit	1.00	\$	Other	Dually eligible (Medicare a members must make a copa Medicare Part B (crossover to Medicaid, for services fo otherwise collects a copayn	nyment for each) claim submitted or which Medicaid	
Serv	vice or Item:	Ion-Emergency us	se of the ER				Remove Se or Item	
ndi	cate the incom	e ranges by which	h the cost sha	ring amoun	t for this service	e or item varies.		_
		Incomes Less than or Equal to		Dollars or Percentage	Unit	Explanation	on	_
+	0%	50%	0.00	\$	Visit			
+	50%	No upper limit	3.00	\$	Visit		Copayment charged for nonemergency services when provided in a hospital emergency room.	
Se ₁	rvice or Item							_
Sha	uring for Non-	-preferred Drugs	Charged to	Otherwise	Exempt Indiv	iduals		
	_	t sharing for non-p			-			

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

No

Transmittal Number: IA-17-0009 Supersedes Transmittal Number: IA-16-002 Approved Effective Date: July 1, 2017 Page 5 of 6 Approval Date: October 19, 2017



Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise <u>Exempt</u> Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.

No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Transmittal Number: IA-17-0009 Supersedes Transmittal Number: IA-16-002 Approved Effective Date: July 1, 2017
Approval Date: October 19, 2017 Page 6 of 6