2016 Comparison of the State of Iowa Medicaid Enterprise
Basic Benefits Based on Eligibility Determination

	Medicaid	Iowa Health and Wellness (IHAWP)	Iowa Family Planning Network (IFPN)	*hawk-i*
General Plan Provisions				
Benefits Available from Out-of-Network Providers	Please contact Member Services to determine the requirements for using an out-of-network provider.	Please contact Member Services to determine the requirements for using an out-of-network provider.	Please contact Member Services to determine the requirements for using an out-of-network provider.	Please contact Member Services to determine the requirements for using an out-of-network provider.
Cost Sharing: A variety of methods are used to share expenses between the State and a member. These methods include monthly cost shares, co-pays, and premiums.	Variable copayments based on eligibility are not listed. Please contact member services for further details.	Variable copayments based on eligibility are not listed. Please contact member services for further details.	No copayments or other cost sharing.	Variable copayments based on eligibility are not listed. Please contact member services for further details.
Copayments				
Persons under age 21, all services	$0.00	$0.00	$0.00	$0.00
Persons over age 21, most services	$1.00 to $3.00 based on types of services	$0.00 (except for emergency services)	$0.00	Not applicable
Persons receiving long-term care institutional	Based on family income level	Not applicable	Not applicable	Not applicable
Copayment exceptions				
Family planning services or supplies regardless of age	$0.00	$0.00	$0.00	$0.00
Pregnant women, all services	$0.00	$0.00	$0.00	$0.00
Emergency services	$0.00	$0.00	$0.00	$0.00

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Members under the age of 21	$0.00	$0.00	$0.00	$0.00
Preventative Services				
Affordable Care Act (ACA) preventive services	Covered	Covered	Not Covered	Covered
Routine Check-ups	Covered	Covered, limitations may apply	Limited to Family Planning Services and Family Planning related services only	Covered
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered	Covered up to age 21	Not Covered	Not Covered
Immunizations	Covered	Covered, limitations may apply	Not Covered	Covered, limitations may apply
Professional Office Services				
Primary Care Provider	Covered	Covered	Limited to Family Planning Services and Family Planning related services only	Covered
Office Visit	Covered	Covered	Limited to Family Planning Services and Family Planning related services only	Covered
Allergy Testing	Covered	Covered	Not Covered	Covered
Allergy Serum and Injections	Covered	Covered	Not Covered	Covered
Certified Nurse Midwife services	Covered	Covered	Not Covered	Covered
Chiropractor	Covered Limitations may apply	Covered Limitations may apply	Not Covered	Covered, limitations may apply

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Contraceptive Devices	Covered	Covered	Covered	Covered
Diabetic self-management training	Covered Once per member, lifetime maximum	Covered – 10 hours of outpatient self-management training within a 12 month period, plus follow-up training of up to 2 hours annually	Not Covered	Covered
Family Planning and Family Planning related services	Covered	Covered	Covered	Covered
Gynecological exam	Covered	Covered, limited to one visit per year	Covered	Covered
Injections	Covered, limitations may apply	Covered, limitations may apply	Covered for Family Planning and Family Planning related services	Covered, limitations may apply
Laboratory Tests	Covered	Covered	Covered for Family Planning and Family Planning related services	Covered
Newborn child - office visits	Covered	Covered	Not Covered	Covered
Podiatry	Covered Routine foot care is not covered unless it is part of a member's overall treatment related to certain health care conditions.	Covered Routine foot care is not covered unless it is part of a member's overall treatment related to certain health care conditions.	Not Covered	Covered, limitations may apply

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Routine Eye Exam *One routine vision exam per calendar year.*	Covered	Covered	Not Covered	Covered
Routine Hearing Exam *One routine hearing exam per calendar year.*	Covered	Covered	Not Covered	Covered
Specialist Office Visit	Covered, PCP Referral may be required	Covered. PCP Referral may be required	Limited to Family Planning Services and Family Planning related services only	Covered, PCP Referral may be required
Hospital Services				
Inpatient Hospital Admissions				
Preapproval of Inpatient Admissions	Required for non-emergent admissions	Required for non-emergent admissions	Not Covered	Required for non-emergent admissions
Inpatient Hospital Services				
Room and Board	Covered	Covered	Not Covered	Covered
Inpatient Physician Services	Covered, includes anesthesia	Covered, includes anesthesia	Not Covered	Covered
Inpatient Supplies	Covered	Covered	Not Covered	Covered
Inpatient Surgery	Covered	Covered	Not Covered	Covered
Bariatric Surgery for morbid obesity	Covered	Not Covered	Not Covered	Not Covered
Breast reconstruction, following breast cancer and mastectomy	Covered	Covered	Not Covered	Covered, limitations may apply
Organ/bone marrow transplants	Covered, limitations apply	Covered, limitations apply	Not Covered	Covered, limitations apply
Outpatient Hospital Services				
Abortions	Certain circumstances must apply. Contact Member	Certain circumstances must apply. Contact Member	Not Covered	Covered, certain circumstances must apply. Contact Member

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	Services.	Services.		Services.
Ambulatory Surgical Center	Covered, includes anesthesia	Covered, includes anesthesia	Covered, includes anesthesia for Family Planning and Family Planning related services	Covered, includes anesthesia
Chemotherapy	Covered	Covered	Not Covered	Covered
Dialysis	Covered	Covered	Not Covered	Covered
Outpatient Diagnostic Lab, Radiology	Covered	Covered	Covered for Family Planning and Family Planning related services	Covered
Emergency Care				
Ambulance	Covered	Covered	Not Covered	Covered
Urgent Care Center	Covered	Covered	Not Covered	Covered
Hospital Emergency Room	Covered $3.00 per visit for non-emergent medical services	Covered $8.00 per visit for non-emergent medical services	Not Covered	Covered, emergency services for non-emergent conditions are subject to a $25 copay if the family pays a premium for the hawk-i program
Non-Emergency Medical Transportation (NEMT)	Covered	Not Covered	Not Covered	Not Covered
Behavioral Health Services				
Assertive Community Treatment (ACT)	Covered	Not Covered	Not Covered	Not Covered
Behavioral Health Intervention Services (BHIS), including applied behavior analysis.	Covered	Covered Residential treatment is not	Not Covered	Not Covered

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		covered		
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment)	Covered, (MCO members only)	Not Covered	Not Covered	Not Covered
Inpatient mental health and substance abuse treatment	Covered	Covered Residential treatment is not covered.	Not Covered	Covered
Office Visit	Covered	Covered	Not Covered	Covered
Outpatient mental health and substance abuse	Covered	Covered	Not Covered	Covered
Psychiatric Medical Institutions for Children (PMIC)	Covered	Covered for 19 to 20 year olds. Limitations may apply	Not Covered	Not Covered
Outpatient Therapy Services				
Cardiac Rehabilitation	Covered, Prior authorization may be required	Covered	Not Covered	Covered
Occupational Therapy	Covered, Prior authorization may be required	Limited to 60 visits per year	Not Covered	Not Covered
Oxygen Therapy	Covered, Prior authorization may be required	Limited to 60 visits in a 12-month period	Not Covered	Covered, limitations may apply

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Physical Therapy	Covered, Prior authorization may be required	Limited to 60 visits per year	Not Covered	Covered, limitations may apply
Pulmonary Therapy	Covered, Prior authorization may be required	Limited to 60 visits per year	Not Covered	Covered, limitations may apply
Respiratory Therapy	Covered, Prior authorization may be required	Limited to 60 visits per year	Not Covered	Covered, limitations may apply
Speech Therapy	Covered, Prior authorization may be required	Limited to 60 visits per year	Not Covered	Covered, limitations may apply
Prescription Drug Coverage				
Quantity	31-day supply for all prescriptions except contraceptives which is a 90-day supply.	31-day supply for all prescriptions except contraceptives which is a 90-day supply.	31-day supply for all prescriptions for Family Planning and Family Planning related purposes except contraceptives which is a 90-day supply.	31-day supply for all prescriptions except contraceptives which is a 90-day supply.
Prescription Drug Copay				
Generic Copay	Covered, $1.00 Copay	Covered, $0.00 Copay	Covered for Family Planning and Family Planning related purposes only $0.00 Copay	Covered, $0.00 Copay
Preferred Brand-name	Covered, $1.00 Copay	Covered, $0.00 Copay	Covered for Family Planning and Family Planning related	Covered, $0.00 Copay

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	Medicaid	Iowa Health and Wellness (IHAWP)	Iowa Family Planning Network (IFPN)	*hawk-i*
			purposes only $0.00 Copay	
Non-preferred Brand-name	Covered $1.00 Copay for prescriptions under $25.00 $2.00 Copay for prescriptions between $25.01 to $50.00 or the preferred copay with a Prior Authorization $3.00 Copay for prescriptions $50.01 or more or the preferred copay with a Prior Authorization	Covered, $0.00 Copay	Covered for Family Planning and Family Planning related purposes only $0.00 Copay	Covered, $0.00 Copay
Prescription Oral Contraceptives	Covered, $0.00 Copay	Covered, $0.00 Copay	Covered, $0.00 Copay	Covered, $0.00 Copay
Prescription and Non-Prescription Drugs for Smoking Cessation	Covered, $0.00 Copay	Not Covered	Not Covered	Not Covered
Radiology Services				
Mammography	Covered	Covered	Not Covered	Covered
Routine Radiology Screening and Diagnostic Services	Covered	Covered	Covered for Family Planning and Family Planning related purposes only	Covered
Sleep study testing	Covered	Covered, Sleep Apnea diagnostic services only	Not Covered	Covered
Laboratory Services				

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Colorectal Cancer Screening	Covered	Covered	Not Covered	Covered
Diagnostic genetic testing	Covered, Prior Authorization required	Covered, Prior Authorization required	Not Covered	Covered
Pap Smears	Covered	Covered	Covered	Covered
Pathology Tests	Covered	Covered	Covered for Family Planning and Family Planning related purposes only	Covered
Routine Laboratory Screening and Diagnostic Services	Covered	Covered	Covered	Covered
Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing	Covered	Covered	Covered	Covered
Durable Medical Equipment (DME)				
Medical Equipment and supplies	Covered	Covered	Not Covered	Covered
Diabetes equipment and supplies	Covered	Covered, limitations may apply	Not Covered	Covered
Eye Glasses	Covered, limitations may apply	Covered for ages 19 to 20, limitations may apply	Not Covered	Covered, limitations may apply
Hearing Aids	Covered	Covered for ages 19 to 20, limitations may apply	Not Covered	Covered, limitations may apply
Orthotics	Covered, limitations may apply	Covered, limitations may apply	Not Covered	Covered, limitations may apply
Long Term Services Supports (LTSS) – Community Based				
Case Management	Covered for individuals with a developmental disability and	Not Covered	Not Covered	Not Covered

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	HCBS Waiver populations only			
Child Care Medical Services	Covered	Not Covered	Not Covered	Not Covered
Private Duty Nursing/Personal Cares per EPSDT authority	Covered up to age 21 under EPSDT	Covered up to age 21 under EPSDT	Not Covered	Not Covered
Section 1915(C) Home and Community-Based Services (HCBS)	Covered	Not Covered	Not Covered	Not Covered
Section 1915(I) Habilitation Services	Covered	Not Covered	Not Covered	Not Covered
Home Health Services (state plan and LTSS) • Home Health Aid • Skilled Nursing • Therapies (PT/OT/Speech)	Covered	Covered	Not Covered	Covered (except for OT)
Long Term Services and Support (LTSS) – Institutional				
ICF/ID (Intermediate Care Facility for individuals with Intellectual Disabilities)	Covered, limitations apply	Not Covered	Not Covered	Not Covered
Nursing Facility (NF) and Nursing Facility for the Mentally Ill (NF/MI)	Covered, limitations apply	Not Covered	Not Covered	Not Covered
Skilled Nursing Facilities (SNF)	Covered, limitations apply	Covered, limitations apply Limited to 120 day stays	Not Covered	Covered
Special Population Skilled Nursing Facility Out of State (Skilled preapproval)	Covered, limitations apply	Not Covered	Not Covered	Not Covered
Hospice				

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Daily Categories: • Routine care ○ *If member is residing in a Nursing Facility, room and board charges covered at 95%* • Facility respite • Inpatient hospital • Continuous	Covered	Covered, limitations apply	Not Covered	Covered
Health Homes				
Chronic Condition Health Homes	Covered	Covered if member has been determined to be medically exempt.	Not Covered	Not Covered
Integrated Health Homes	Covered	Covered if member has been determined to be medically exempt.	Not Covered	Not Covered