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SUPPLEMENT 2 TO ATTACHMENT 3.1-A
LIMITATIONS ON AMOUNT DURATION AND SCOPE

1. INPATIENT HOSPITAL SERVICES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES)

Iowa Medicaid does not cover the following inpatient hospital services:

(1) Private duty nursing services.

(2) Surgical procedures that can be safely and effectively performed on an outpatient basis. These procedures are published by the Iowa Medicaid agency in "Outpatient/Same Day Surgery List".

The following services are available subject to limitations:

(1) Services provided in connection with dental treatment are covered only when the mental, physical or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

2a. OUTPATIENT HOSPITAL SERVICES

Emergency room services are covered by Iowa Medicaid only if at least one of the following conditions is met:

(1) The patient is evaluated or treated for a medical emergency, accident or injury.

(2) The patient's evaluation or treatment results in a utilization review committee approved inpatient hospital admission.

(3) The patient is referred by a physician.

(4) The patient is suffering from an acute allergic reaction.

(5) The patient is experiencing acute, severe respiratory distress.

Iowa Medicaid covers the following types of outpatient hospital services that are not generally furnished on an outpatient basis.

(1) *Alcoholism and substance abuse.*

(2) *Eating disorders.*

(3) *Cardiac rehabilitation.* .

(4) *Outpatient mental health services.*

(a) Partial hospitalization sessions are limited to four to eight hours per day.

(b) Day treatment sessions are limited to three to five hours per day, three or four times per week.

(5) *Pain management.* Iowa Medicaid will cover a maximum of four weeks of a structured outpatient treatment program. A repeat of the entire program for any

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patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

(6) *Diabetic education.* Iowa Medicaid will cover diabetic education services only once in a lifetime of the recipient. The "once/lifetime" limit applies to any given Medicaid member's participation in an outpatient diabetic education program, at a hospital that has received certification for providing this (outpatient) program. The purpose and intent of that education program is to educate members about diabetes, self-care, insulin use, dietary issues, etc. Any medically necessary medical care/services related to a given member's diabetes would be paid separately outside of the outpatient diabetic education program.

(7) *Pulmonary rehabilitation.*

2b. RURAL HEALTH CLINIC SERVICES AND OTHER AMBULATORY SERVICES FURNISHED BY A RURAL HEALTH CLINIC WHICH ARE OTHERWISE INCLUDED IN THE PLAN

Other ambulatory services furnished by a rural health clinic which are otherwise included in the State plan must meet the specific Iowa State plan requirements for furnishing those services and are subject to the same limitations regarding amount, duration, scope.

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Other ambulatory services furnished by a Federally qualified health center which are otherwise included in the State plan must meet the specific Iowa State plan requirements for furnishing those services and are subject to the same limitations regarding amount, duration, scope.

3. RESERVED

4a. NURSING FACILITY SERVICES

Nursing Facility services must be ordered by a physician who has either (1) identified to recipient or his representative alternatives to placement in a nursing home and provided guidance on how to access such alternatives, or (2) documented in the recipient's clinical record why the physician determined that the identification of alternatives was unnecessary or inappropriate.

4b. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES (EPSDT)

Pursuant to 42 CFR 441.56(a)(2)(iii) Iowa Medicaid covers services provided under the EPSDT program to all eligible individuals up to age 21 without cost.

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Pursuant to 1905 R of the Social Security Act, Iowa Medicaid covers those medical or remedial care services described in section 4b for all children to age 21, services which are specified in 42 CFR 440 but are not provided to other recipients or are provided to other recipients in a lesser amount, duration or scope. (These services are referred to herein as "*EPSDT Services*"). *EPSDT Services* are available to all Iowa Medicaid members up to age 21, except those specifically excluded by federal regulation (e.g. 42 CFR 441.13 which prohibits FFP in expenditures for services for any individual who is in a public institution, as defined in 435.1009).

The State of Iowa has elected under 34 CFR 300.142(e) to "use the [Iowa] Medicaid...[program] in which a child participates to provide or pay for services required under this part [300 (Assistance to states for the education of children with disabilities) of Title 34 (Education) the Code of Federal Regulations], as permitted under the public insurance [Medicaid] program." Some of the services provided to such children are *EPSDT Services.*

Additionally, the State of Iowa has elected to use the Iowa Medicaid program to pay for services required under Part 303 (Early Intervention Program for Infants and Toddlers with Disabilities) of Title 34 (Education) of the Code of Federal Regulations. Some of the services provided to such children are *EPSDT Services*.

When a service could be covered as a non- EPSDT service or as a *EPSDT Service* and the *EPSDT Services* are broader in amount, duration or scope, they are covered as *EPSDT Services*. Additionally, when *EPSDT Services* are identical to non-EPSDT services, but have less restrictive prior authorization rules, the less restrictive prior authorization rules apply. The policies described in this paragraph apply to all children under age 21, without regard to whether the services are provided in connection with services to a child under part 300 or Part 303 of Title 34 of the Code of Federal Regulations.

Subsection (c) of 42 CFR 441.61(Utilization of providers and coordination with related programs) encourages that state Medicaid programs to "make use of other public health, mental health and education and related programs ... to ensure an effective child health program. Similar provisions can be found in Title IV. Pursuant to this, when a child has been identified by an agency authorized to do so under those Iowa State law or regulations which implement Part 300 or Part 303 of the Code of Federal Regulations, as requiring services covered under the Iowa Medicaid program, no further prior authorization of those services is required, except in the case of private duty nursing services (as defined in 42 CFR 440.80), personal care services (as defined in 440.167), and home health services - home health aide services (as defined in 440.70(b)(2)). Such agencies may also be providers of such services if they have employment or contractual agreements with

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licensed practitioners of the healing arts acting within the scope of their practice. Such agencies include:

(1) Local Education Agencies (LEAs) – which are local school districts;

(2) Area Education Agencies (AEAs), - which are established under Section 273 of the Iowa Code. AEAs are separate public entities that provide services to pupils enrolled in public or non-public schools that may not be available from the pupils LEA; and

(3) Public agencies certified by the Iowa Department of Education as in good standing under the Infant and Toddlers with Disabilities Program under Part 303 of the Code of Federal Regulations.

Iowa Medicaid covers the following Services not otherwise included in the Medicaid State Plan:

(1) *Outpatient Hospital Services (as defined in 42 CFR 440.20(a)).* Day treatment and partial hospitalization.

(2) *Services of Licensed Practitioners of Healing Arts other than Physicians.* (Reference 42 CFR 440.110 or 42 CFR 440.60). Iowa Medicaid covers the following EPSDT Services furnished by licensed practitioners of the healing arts acting within the scope of their practice as defined by State law.

a. Audiologist. The following services are covered when provided by licensed audiologist within the scope of his or her practice as defined by state law and regulation referenced below: Measuring, testing, evaluation, consultation, counseling, rehabilitation, or remediation related to disorders and conditions in individuals, including the determination and use of appropriate amplification.

Reference: Iowa Administrative Code Part 281 (Education) – Chapter 41 (Special Education), Section 281-41.9(3)(b) (Authorized Personnel, Special Education Support Personnel, "Audiologist").

See also Iowa Administrative Code Part 282(Educational Examiners), Chapter 15 (Requirements for Special Education Endorsements), Section 15.3(7) (School Audiologist), which stipulate requirements for a masters or doctoral degree for audiologists and a Certificate of Clinical Competence in Audiology granted by the American-Speech-Language Hearing Association in accordance with 42 CFR 440.110.

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Audiologists may utilize assistants in the delivery of professional services but only to the extent allowable under state law and regulation referenced above. An assistant can only perform those duties and responsibilities for which the assistant has been specifically trained and is qualified to perform. An assistant must receive periodic direct observation and supervision of their activities by the supervising audiologist, in accordance with the requirements of 42 CFR 440.110c.

Iowa Administrative Code Section 281-41.10(2)(a)(256B) (Paraprofessionals, Authorized special education paraprofessionals, "audiometrist") in Chapter 41 (Special Education) of Part 281 (Education Department), which stipulate that, at a minimum, an audiology assistant must be 18 years of age, a high school graduate, or its equivalent, and complete a three-semester-hour (or four-quarter-hour) course in introductory audiology from an accredited institution with 15 hours of instruction in the specific tasks which the assistant will be performing or have completed a minimum training period comprised of 75 clock hours on instruction and practicum experience.

b. Occupational Therapist. The following services are covered when provided by licensed occupational therapist within the scope of his or her practice as defined by state law and regulation referenced below: This includes screening, measuring, testing, evaluation, consultation, counseling, rehabilitation, or remediation related to disorders and conditions in individuals.

Occupational therapists may utilize assistants in the delivery of professional services but only to the extent allowable under state law and regulation referenced below. An assistant can only perform those duties and responsibilities for which the assistant has been specifically trained and is qualified to perform. An assistant must receive periodic direct observation and supervision of their activities by the supervising audiologist, in accordance with the requirements of 42 CFR 440.110b.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 206 (Licensure of Occupational Therapists and Occupational Therapy Assistants) and Chapter 208 (Practice of Occupational Therapists and Occupational Therapy Assistants), which stipulate a degree in occupational therapy from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association and a passing score on the licensure examination for occupational therapists administered by the National Board for Certification in Occupational Therapy in compliance with 42 CFR 440.110b.

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c. Physical Therapist. The following services are covered when provided by licensed physical therapist within the scope of his or her practice as defined by state law and regulation referenced below: This includes screening, measuring, testing, evaluation, consultation, counseling, rehabilitation, or remediation related to disorders and conditions in individuals.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 200 (Licensure of Physical Therapists and Physical Therapy Assistants) and Chapter 201 (Practice of Physical Therapists and Physical Therapy Assistants), which stipulate graduation from a physical therapy program accredited by an approved national accreditation agency and a passing score on the National Physical Therapy Examination or other nationally recognized equivalent examination as defined by the Board of Physical and Occupational Therapy Examiners in compliance with 42 CFR 440.110.

Physical Therapy Assistant. The following services are covered when provided by licensed physical therapy assistant within the scope of his or her practice as defined by state law and regulation referenced below: Screenings, assessments and direct services to an individual and direct services to an individual in a group. An assistant must receive periodic direct observation and supervision of their activities by the supervising physical therapist, in accordance with the requirements of 42 CFR 440.110.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 200 (Licensure of Physical Therapists and Physical Therapy Assistants) and Chapter 201 (Practice of Physical Therapists and Physical Therapy Assistants), which stipulate graduation from a physical therapy assistant program accredited by an approved national accreditation agency and a passing score on the National Physical Therapy Examination or other approved nationally recognized equivalent in compliance with 42 CFR 440.110.

d. School Psychologist. The following services are covered when provided by a certified school psychologist within the scope of his or her practice as defined by state law and regulation referenced below: Screening, counseling, and the use of psychological remedial measures with persons, in groups or individually with adjustment or emotional problems in the areas of family, school, and personal relationships.

Reference: Iowa Administrative Code Part 281 (Education) – Chapter 41 (Special Education), Section 281-41.9(3)(h) (Authorized Personnel, Special Education Support Personnel, "School Psychologist").

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See also Iowa Administrative Code Part 282(Educational Examiners), Chapter 15 (Requirements for Special Education Endorsements), Section 15.3(8) (School Psychologist) which stipulate: (1) Completion of a master's degree of at least 60 semester hours (2) Completion of a specialist's degree (3) Completion of a graduate school psychology program that is currently approved (or was approved at the time of graduation) by the National Association of School Psychologists or the American Psychological Association; or (4) Certification as a Nationally Certified School Psychologist by the National Association of School Psychologists.

e. Speech Pathologist. The following services are covered when provided by licensed speech pathologist within the scope of his or her practice as defined by state law and regulation referenced below: Screening, evaluation, consultation, counseling, rehabilitation or remediation related to the development and disorders of speech, fluency, voice or language for the purpose of evaluating, preventing, ameliorating, modifying, or remediating such disorders and conditions in individuals or groups of individuals.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 300 (Licensure of Speech Pathologists and Audiologists), which stipulates possession of a master's degree or its equivalent, at least nine months of supervised full time clinical experience, a qualifying score on the National Teacher Examination in Speech Pathology and a certificate of clinical competence from the American Speech-Language Hearing Association),in compliance with 42 CFR 440.110c.

Speech pathologists may utilize assistants in the delivery of professional services but only to the extent allowable under state law and regulation referenced above. An assistant must receive periodic direct observation and supervision of their activities by the supervising speech pathologist, in accordance with the requirements of 42 CFR 440.110c. A speech pathologist assistant shall follow the treatment plan written by the supervising speech pathologist in accordance with 42 CFR 440.110c.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 300 (Licensure of Speech Pathologists and Audiologists). Speech pathology assistants must be at least 18 years of age, be a high school graduate or its equivalent and complete a three-semester-hour (or four-quarter-hour) introductory course in speech and language pathology for speech pathology assistants with 15 hours of instruction in specific tasks to be performed or have a minimum training period comprised of 75 clock hours on instruction and practicum experience.

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f. Nurse. Nursing services when provided by licensed nurse within the scope of his or her practice as defined by state law and regulation referenced below.

Reference: Iowa Administrative Code Part 655 (Nursing Board) – Chapter 3 (Licensure to Practice – Registered Nurse/Licensed Practical Nurse).

g. Psychologist. The following services are covered when provided by licensed psychologist within the scope of his or her practice as defined by state law and regulation referenced below. Screening, assessments, psychological testing/evaluation direct therapeutic and/or counseling services rendered to individuals, individually or in a group setting.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 240 (Licensure of Psychologists).

i. Licensed Teacher of the Visually Disabled The following services are covered when provided by a licensed teacher of the visually disabled within the scope of his or her practice as defined by state law and regulation referenced below: Screening and evaluation services.

Reference: Iowa Administrative Code Part 281 (Education) – Chapter 41 (Special Education), Section 281-41.9(2) (Authorized Personnel, Special Education Support Personnel, "Special Educational Instructional Personnel"). See also Iowa Administrative Code Part 282(Educational Examiners), Chapter 15 (Requirements for Special Education Endorsements), Section 15.2(7) (Visually Disabled) which stipulate holding a regular education endorsement and completion of an approved program in visual disabilities from a recognized institution. This includes knowledge of the following: social, emotional and behavioral characteristics of individuals with visual disabilities, assessment, diagnosis and evaluation, appropriate assistive technology, behavioral management and behavioral change strategies, or has an endorsement for visually disabled issued in another state, or if the individual does not also hold or is not eligible for a regular education endorsement in Iowa, additional requirements to those set out above must be met.

j. Early childhood special education specialist. The following counseling services are covered when provided by a licensed early childhood special education specialist within the scope of his or her practice as defined by state law and regulation referenced below: Screening, assessments, and treatment of developmental needs.

Reference: Iowa Administrative Code Part 281 (Education) – Chapter 41 (Special Education), Section 281-41.9(2) (Authorized Personnel, Special Education Support Personnel, "Special Educational Instructional Personnel"). See also Iowa Administrative Code Part 282 (Educational Examiners), Chapter 15 (Requirements for Special Education Endorsements), Section 15.2(19) (Early Childhood Special Education) including the following requirements:
Early Childhood Special Education Specialists must have a baccalaureate or masters degree from a regionally accredited institution.

k. Licensed Social Worker. The following counseling services are covered when provided by licensed social worker within the scope of his or her practice as defined by state law and regulation referenced below: Screening, diagnosing, assessing, treating, and preventing psychosocial disabilities or impairments, including emotional and mental disorders.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 279 (Administrative and Regulatory Authority for the Board of Social Work Examiners), Chapter 281 (Licensure of Social Workers), and Chapter 282 (Practice of Social Workers).

l. Licensed Guidance Counselor. The following counseling services are covered when provided by a licensed guidance counselor within the scope of his or her practice as defined by state law and regulation referenced below: Screening, assessments, and counseling services to individuals or groups.

Reference: Iowa Administrative Code Part 282 (Educational Examiners) – Chapter 14 (Issuance of Practitioner's License and Endorsements), Section 282-14.140(5) and (6) (Requirements for Other Teaching Endorsements, "elementary counselor" and "secondary counselor"). Which stipulates a Master's degree from an accredited institution of higher education.

m. Optometrist. Iowa Medicaid covers identification of the range, nature, and degree of vision loss, consultation with a child and parents concerning a child's vision loss and appropriate selection, fitting or adaption of vision aids, evaluation of the effectiveness of a vision aid, and orientation and mobility services, provided by an optometrist. Optometrist services are limited as follows, with the exception of medically necessary services for children under the age of 21, which are covered in accordance with the EPSDT provisions:

(1) New lenses are limited to once every 24 months for adults when there is a change in the prescription.

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(2) Lenses made of polycarbonate or equal material are allowed for members with vision in only one eye, and members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

(3) New frames are covered when there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(4) Safety frames are allowed for members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

(5) Contact lenses are covered only following cataract surgery, for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatisms, for treatment of acute or chronic eye disease, and when vision cannot be corrected with glasses.

(6) The following services are not covered:
   a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
   b. Glasses for occupational eye safety.
   c. A second pair of glasses or spare glasses.
   d. Cosmetic surgery and experimental medical and surgical procedures.
   e. Contact lenses if vision is correctable with non-contact lenses.
   f. Sunglasses unless medically necessary and tinted lenses do not meet the medical need.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 180 (Licensure of Optometrists) and Chapter 182 (Practice of Optometrists).

n. Dietician. The following nutrition counseling services are covered when provided by a licensed dietician within the scope of his or her practice as defined by state law and regulation referenced below: Assessment and intervention when a nutrition problem or a condition of such severity exists that nutrition counseling is medically necessary.

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Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 81 (Licensure of Dieticians).

(3) *Home Health Services – Nursing Services.* (As defined in 42 CFR 440.70(b)(1)) and *Home Health Aide Services* (As defined in 42 CFR 440.70(b)(2)). Part-time or intermittent nursing services are defined as five non-continuous, skilled nursing visits per week, with the exception of medically necessary services for children under 21 years of age, which are covered in accordance with EPSDT provisions. Part-time or intermittent home health aide is defined as a maximum of 28 hours per week, with the exception of medically necessary services for children under 21 years of age, which are covered in accordance with EPSDT provisions. Home health aide visits can be provided on a daily basis. In accordance with the EPSDT provisions, medically necessary medical supplies, equipment and appliances are covered for children under 21 years of age. Home health aides comply with the provider qualifications found in the conditions of participation at 42 CFR 484.4.

(4) *Private Duty Nursing Services.* (As defined in 42 CFR 440.80) and as further described in Section 4310 (Private Duty Nursing Services) of the State Medicaid Manual. Pursuant to 42 CFR 440.80, Iowa Medicaid covers nursing services for members who require more individual and continuous care than is available under intermittent or part time services. A registered nurse or a licensed practical nurse, under the direction of the member's physician, provides the services in the home or outside of the home, when the member's normal life activities take the recipient outside of the home.

(5) *Dental Services.* (As defined in 42 CFR 440.100). Iowa Medicaid covers the following dental services. In addition, medically necessary dental services for children under 21 years of age are covered in accordance with the EPSDT provisions:

(i) Reimbursement for sealants for children through age 18 for deciduous and posterior teeth.

(ii) Crowns, posts and cores on anterior teeth that have not received endodontic treatment and on posterior teeth.

(iii) The following periodontal services:

(a) Full-mouth debridement once every 24 months.

(b) Periodontal scaling and root planning.

(c) Periodontal surgical procedures after scaling and planning if the patient has demonstrated reasonable oral hygiene, unless unable to do so because of physical or mental disability or in when need arises on account of drug therapy.

(d) Pedicle soft tissue graft and free soft tissue graft; and

(e) Periodontal maintenance therapy

(iv) Endodontic services on posterior teeth.

(v) The following orthodontic procedures:

Orthodontic services to treat the most sever and handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A Salzmann, D.D., American Journal of Orthodontics, October 1968. 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, openbite, and crossbite.

(b) Space management services when there is too little dental ridge to accommodate either the number of the size of teeth and if not corrected significant dental disease will result.

(c) Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required.

(6) *Diagnostic Services*. (As defined in 42 CFR 440.130(a)). Lead investigation services are covered in order to identify the sources of lead poisoning. These services must be provided by the Iowa Department of Public Health (DPH) or an agency certified by the Iowa Department of Public Health as an elevated blood level (EBL) investigation agency.

(6a) *Preventive Services* (As defined in 42 CFR 440.130(c)). Intensive skill building services are covered as follows for children less than 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions. Intensive skill building is a service recommended by a physician or other licensed practitioner of the healing arts to promote mental health efficiency; and is for the express purpose of treating or minimizing the adverse effects of impairments to an individual's mental health. The services are covered as follows.

a. There has been an appropriately documented diagnosis by a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under State law.

b. The services must be recommended by a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under State law. The services are provided pursuant to an individualized plan of treatment for the individual receiving the services. The plan of treatment must be developed by a Board Certified Behavior Analyst (BCBA). The BCBA must be certified by the national credentialing body: the Behavior Analyst Certification Board. The plan must be:

i. Consistent with the documented diagnosis of disability in (a) above;
ii. Developed and documented in accordance with the standards of good medical practice; and
iii. Provide for ongoing reevaluation of the plan of care to ensure the services provided remain appropriate, are minimizing the identified adverse behaviors, and promote physical and mental health.

c. Services include the following:

Service	Definition
Individual Direct Skills Training and Development	The service is designed to treat inappropriate behaviors and prevent more serious mental health symptoms, communication problems, and problem behaviors in the future. It includes one to one skill building services to increase positive and reduce negative behaviors. The service includes skill modeling, feedback, and reinforcement of appropriate social behaviors and reduction of maladaptive behaviors. It is designed to reduce maladaptive behaviors while simultaneously increasing appropriate socially significant behaviors. The services can be provided by a BCBA, board certified assistant behavior analyst, or non-certified staff who has a bachelor's degree in education, psychology, social work, occupational therapy, physical therapy, and speech language pathology.
Functional Behavior Assessment	Assessment of the child to determine the function of maladaptive behaviors subsequent to the diagnosis and to determine appropriate treatment options and recommendations. It is performed by a BCBA using a nationally recognized standardized behavior assessment tool.
Family Training	The service is designed to treat inappropriate behaviors and prevent more serious mental health symptoms, communication problems, and problem behaviors in the future. The service includes skill modeling, feedback, and reinforcement to family members or caregivers. Skill teaching and reinforcement at home to family members or caregivers to ensure treatment strategies are being transferred. This service is for the direct benefit of the Medicaid eligible individual. Treatment interventions that are implemented need to be transferred and implemented by the family or caregiver for reinforcement, redirection, and promotion. The services can be provided by a BCBA, board certified assistant behavior analyst, or non-certified staff who has a bachelor's degree in education, psychology, social work, occupational therapy, physical therapy, and speech language pathology
Skills Training and Development-group	The service is designed to treat inappropriate behaviors and prevent more serious mental health symptoms, communication problems, and problem behaviors in the future. Skill teaching to increase positive or reduce negative behaviors within a group of children. The service includes skill modeling, feedback, and reinforcement of appropriate social behaviors and reduction of maladaptive behaviors. One to one intervention in a group setting, to work towards generalization of skills and behavior addressed in home programming. The services can be provided by a BCBA, board certified assistant behavior analyst, or non-certified staff who has a bachelor's degree in education, psychology, social work, occupational therapy, physical therapy, and speech language pathology.

a. Types of non-licensed practitioners providing the service are board certified behavioral analyst; board certified assistant behavior analyst, or non-certified staff who has a bachelor's degree in education, psychology, social work, occupational therapists, physical therapists, and speech language pathologists.

b. A description of the qualifications and supervision follows:

- Board certified behavioral analysts who have a master's degree in behavior analysis or other natural science, education, psychology, social work, or a field related to behavior analysis and are certified by the Behavior Analyst Certification Board. Board certified assistant behavior analyst (BCABA) have a bachelor's degree and

135 hours of education in ethical considerations, definition & characteristics and principles, processes & concepts, behavioral assessment and selecting intervention outcomes & strategies, experimental evaluation of interventions, measurement of behavior and displaying & interpreting behavioral data, and behavior change procedures and systems support. A practicum must be completed. They are supervised by a BCBA.

- Education staff must have a bachelor's degree in an education program and be participating in an educational program approved by the Behavior Analyst Certification Board leading to a BCBA or a BCABA. They are supervised by a BCBA.
- Psychology staff has a bachelor's degree in psychology and be participating in an educational program approved by the Behavior Analyst Certification Board leading to a BCBA or a BCABA. They are supervised by a BCBA.
- Social work staff must have a bachelor's degree in social work and be participating in an educational program approved by the Behavior Analyst Certification Board leading to a BCBA or a BCABA.. They are supervised by a BCBA.
- Individuals with a bachelor's degree in occupational therapy who are participating in an educational program approved by the Behavior Analyst Certification Board leading to a BCBA or a BCABA. They are supervised by a BCBA.
- Individuals with a bachelor's degree in physical therapy who are participating in an educational program approved by the Behavior Analyst Certification Board leading to a BCBA or a BCABA. They are supervised by a BCBA.
- Individuals with a bachelor's degree in speech language who are participating in an educational program approved by the Behavior Analyst Certification Board leading to a BCBA or a BCABA. They are supervised by a BCBA.

Provider Qualifications

Provider/ Practitioners	Service	Minimum Level of Education / Degree / Experience Required	License / Certification Required	Clinical Supervision
Skills Training and Development Staff	Direct Skills Training and Development (individual and group), Family Training,	Individuals with a Bachelor's degree in education, psychology, social work, occupational therapy, physical therapy, speech/language therapy, who are participating in an educational program approved by the BACB leading to a BCBA or BCABA and supervised by a BCBA.	None	Board Certified Behavior Analyst.
Behavior analyst	Functional Behavior Assessment	Individuals with a Master's degree in behavior analysis or other natural science, education, psychology, social work, or a field related to behavior analysis	Board Certified Behavior Analysis	None

(7) *Rehabilitative services.* (As defined in 42 CFR 440.130(d)), not otherwise covered under this Item 4b, are covered as follows, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions:

a. There has been an appropriately documented diagnosis of a mental disability by a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under State law.

b. The services are provided pursuant to an individualized plan of treatment for the individual receiving the services that have been recommended by a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under State law. The plan must be:

i. Consistent with the documented diagnosis of disability in (a) above;

ii. Developed and documented in accordance with the standards of good medical practice; and

iii. Time limited, or otherwise provide for periodic evaluation of the impact of the services provided under the plan to assure that the plan as implemented remains appropriate for the maximum reduction of the mental disability of the individual and the restoration of the individual to his or her best possible functional level.

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c. The rehabilitative services provided under the plan, which is described in (b) above, are appropriately documented by the rehabilitative services provider(s) in a manner which permits a physician or other licensed practitioner of the healing arts to determine that the plan as implemented remains appropriate for the maximum reduction of the mental disability of the individual and the restoration of the individual to his or her best possible functional level, and such a determination is periodically made and documented by a physician or other licensed practitioner of the healing arts.

d. *Behavioral Health Intervention Services,* Refer to Supplement 2 to Attachment 3.1-A, page 31f, Item 13d(6)

e. *Drug & Alcohol Services,* Refer to Supplement 2 to Attachment 3.1-A, page 31h, Item 13d(7)

(8) *Transportation Services.* (As defined in 42 CFR 440.170(a)). Non-emergency transportation in a vehicle specially equipped or staffed to accommodate the individual's special medical needs or who reside in an area in which school bus transportation is not provided but transportation is medically necessary for the individual. School based transportation is available on any day when the following two conditions are met.

1. On days when the child receives transportation to obtain a Medicaid covered service and;
2. Both the Medicaid covered service and the need for transportation are included in the child's IEP or IFSP if the child receives a Medicaid covered IDEA service at an off-site facility during the school day the cost of transportation from the school to the facility and back to the school is reimbursable in full, however no cost of transportation to and from the child's home and school is reimbursable.

(9) *Personal Care Services* as defined in 42 CFR 440.167 and further described in Section 4480 (Personal Care Services) of the State Medicaid Manual. This can be provided in the home or outside of the home. A physician or other licensed professional within the scope of his or her practice as defined by state law and regulation in accordance with a plan of care must authorize the services. The services must be provided by an adult who is able to perform the cares the member needs and who is not a member of the members' family. Providers of personal care include home health agencies and local education agencies.

4c. Family Planning Services do not include the treatment of infertility.

5a. PHYSICIANS SERVICES

Iowa Medicaid will not cover the following services when rendered by a physician:

(a) Treatment of flat foot; and
(b) Routine foot care
(c) Acupuncture
(d) Cosmetic, reconstructive or plastic surgery where the primary purpose is to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions.

i. Cosmetic, reconstructive or plastic surgery is covered under limited circumstances where such is for the purpose of correcting congenital anomalies; restoration of body form and/or function following

accidental injury; or the revision of disfiguring or extensive scarring resulting from neoplastic surgery.

(e) Surgical or medical procedures for the purpose of or related to sex reassignment.

5b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST IN ACCORDANCE WITH SECTION 1905(a)(5)(B) OF THE ACT

Iowa Medicaid covers medical and surgical services performed by a dentist to the extent these services may be performed under State law by doctors of medicine, osteopathy, dental surgery, or dental medicine and would be covered if furnished by doctors of medicine and osteopathy.

6a. PODIATRISTS SERVICES

Iowa Medicaid covers only those medical or remedial care or services provided by a doctor of podiatric medicine, acting within the scope of his or her license, if the services would be covered as physicians' services when performed by a doctor of medicine or osteopathy. Additionally, Iowa Medicaid does not cover the following services:

(f) Treatment of flat foot;
(g) Treatment of subluxations of the foot; and
(h) Routine foot care.

Podiatrists services are limited except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions.

6b. OPTOMETRIST SERVICES

Iowa Medicaid covers optometric services subject to the following limitations regarding amount, duration and scope, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions:

(1) Routine eye examinations are covered once in a 12-month period.
(2) Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.
(3) Lenses made of polycarbonate or equal material are allowed only for:
    (i) Members with vision in only one eye.

(ii) Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

(4) New frames are covered when there is a prescribed lens change and the new lenses cannot be accommodated by the current frame.

(5) Safety frames are allowed for members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

(6) Replacement of lost or damaged glasses is limited to once every 12 months for adults aged 21 and over, except for people with a mental or physical disability. Glasses can be provided earlier than the 12 months based on medical necessity.

(7) Fitting of contact lenses are covered only following cataract surgery, for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatisms, for treatment of acute or chronic eye disease, and when vision cannot be corrected with glasses.

The following services are not covered:

(1) Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
(2) Glasses for occupational eye safety.
(3) A second pair of glasses or spare glasses.
(4) Cosmetic surgery and experimental medical and surgical procedures.
(5) Contact lenses if vision is correctable with non-contact lenses.
(6) Sunglasses unless medically necessary and tinted lenses do not meet the medical need.

6c. CHIROPRACTOR'S SERVICES

Chiropractor services include only services that:

(1) Are provided by a chiropractor who is licensed by the State of Iowa, or the state in which they reside and practice, and who meets the standards (if any) issued by the Secretary of the United States Department of Health and Human Services; and
(2) Consists of manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuromusculoskeletal condition specified by the Iowa Medicaid Agency in its provider manual which manual manipulation is appropriate treatment.

An x-ray must document the primary regions of subluxation being treated. No x-ray is required for pregnant women and for children age 18 and younger. This x-ray is covered by Iowa Medicaid if it otherwise meets the requirements for a covered x-ray under Item 3 Attachment 3.1.1-A.

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(1) Iowa Medicaid Agency in its provider manual which manual manipulation is appropriate treatment.

An x-ray must document the primary regions of subluxation being treated. No x-ray is required for pregnant women and for children age 18 and younger. This x-ray is covered by Iowa Medicaid if it otherwise meets the requirements for a covered x-ray under Item 3 Attachment 3.1.1-A.

6d1. RESERVED

6d2. RESERVED

6d3. RESERVED

6d4. SERVICES OF HEARING AID DISPENSERS
Iowa Medicaid covers only those services of hearing aid dispensers related to hearing aids prescribed by a licensed audiologist or physician (M.D. or D.O.).

6d5a. PSYCHOLOGY
Iowa Medicaid covers services by licensed psychologists within the scope of the psychologist's licensure.

6d5b. SOCIAL WORKER PROVIDER
Iowa Medicaid covers services by a licensed social worker, within the scope of his or her license, when provided as part of a written plan of treatment. The services may also be provided by a Medicare certified home health agency.

6d6. BEHAVIORAL HEALTH PROVIDER
Iowa Medicaid covers services provided by a licensed marital and family therapist and licensed mental health counselor, within the scope of his or her license as part of a written plan of treatment. Iowa Medicaid covers services provided by an alcohol and drug counselor certified by the Iowa Board of Certification.

6d7. Physician Assistant
Iowa Medicaid covers services provided by a licensed physician assistant within their scope of practice in accordance with state law.

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6d8. A. SERVICES OF ADVANCED REGISTERED NURSE PRACTITIONERS

Payment shall be made to directly to advanced registered nurse practitioners (ARNP) who elect to enroll individually as Iowa Medicaid providers for services provided within the scope of practice and limitations of state law, without regard to whether the ARNP is employed by or associated with a physician, hospital or other health care provider recognized under state law. When a payment has been made to the ARNP for services provided by the ARNP, no payment shall be made to any other provider for the same services for which the ARNP has been paid directly.

Pursuant to 42 CFR 447.10, at the option of an ARNP, payment for the services of an ARNP, including, without limitation a certified-nurse midwife (as defined in Section 655-7.1(152) of Part 655 (Nursing Board), Chapter 7 (Advanced Registered Nurse Practitioners) of the Iowa Administrative Code.), may be made to public or private organization for delivering health care services, if the ARNP has a contract under which the organization submits the claim.

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Iowa Medicaid does not cover services provided by advanced registered nurse practitioners which would not otherwise be covered as physician services or not otherwise payable under any other applicable rule.

6d8. B. SERVICES OF CERTIFIED REGISTERED NURSE ANESTHESTIST

Pursuant to 42 CFR 447.10, at the option of an CRNA, payment for the services of an CRNA, may be made to public or private organization for delivering health care services, if the CRNA has a contract under which the organization submits the claim.

6d9. CERTAIN PHARMACIST SERVICES

Licensed Pharmacist can provide services that are within their scope of practice in accordance with state law.

6d10. SERVICES OF ADVANCED NURSE PRACTITIONERS CERTIFIED IN PSYCHIATRIC OR MENTAL HEALTH SPECIALITIES

Coverage under this Item is limited to services provided by independently practicing advanced registered nurse practitioners certified in psychiatric or mental health specialties within the scope of their practice, including advanced nursing and physician delegated functions under a protocol with a collaborating physician. It does not include services that would not be covered if provided by a physician under the State Plan.

7a. RESERVED

7b. HOME HEALTH SERVICES – NURSING

In addition to the rules contained in 42 CFR 440.70 (Home Health Services), the following limitation applies to nursing services under Iowa Medicaid, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions:

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(1) Nursing visits are limited to 5 per week per recipient.
Additional nursing visits may be provided with submission of an exception to policy with adequate medical documentation to support medical necessity.

7c. HOME HEALTH SERVICES – HOME HEALTH AIDE

In addition to the rules contained in 42 CFR 440.70 (Home Health Services), the following limitations apply to home health aide services under Iowa Medicaid, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions:

(1) Home health aide services provide personal care services for activities of daily living that the member would ordinarily perform if otherwise able. Home health aide services do not provide skilled services. When the primary need of the recipient is for personal care, household services may be provided by the aide to prevent or postpone the recipient's institutionalization. The household services must be incidental and not substantially increase the time spent in the home by the aide.
(2) The services shall be provided under the supervision of a registered nurse, physical, speech or occupational therapist.
(3) Home health aide daily care may be provided to persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.
(4) Home health aide visits are limited to 28 per week per recipient.

Additional home health aide may be provided with submission of an exception to policy with adequate medical documentation to support medical necessity.

7d. HOME HEALTH – MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES

In addition to the rules contained in 42 CFR 440.70 (Home Health Services), the purchase or rental of medical supplies, equipment and appliances under Iowa Medicaid are covered when prescribed by a physician. To qualify as a covered service, the item must be medically necessary and meet the definitions in the Iowa Administrative Code, the state regulations that govern the Iowa Medicaid program. Coverage is limited to the least costly item that will meet the medical needs of the member. Coverage is in compliance with the guidance provided in the September 4, 1998 SMD letter related to the DeSario v Thomas decision.

Each specific item covered is identified by procedure code and name and is listed on the fee schedules published on the Iowa Medicaid Enterprise website. Specific coverage criteria are included in the Provider Manual, also published on that website. Prior authorization is

required for certain items. Services requiring prior authorization and the criteria for approval are listed in the Iowa Administrative Code as well as the Provider Manual. When a request for prior authorization is denied, the requesting provider as well as the member are sent a Notice of Decision advising of the right to appeal the denial and the process for doing so in compliance with 42 CFR Part 431 Subpart E. Additionally, an exception to policy may be requested in exceptional or unusual situations for otherwise non-covered items, including for both children and adults.

Coverage for medical equipment and supplies does not generally include members living in nursing homes or intermediate care facilities for persons with an intellectual disability. Coverage is allowed for orthotics and prosthetics for members residing in these facilities.

Items that are not primarily and customarily used to serve a medical purpose are not covered.

7e. HOME HEALTH SERVICES – PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

Services and Provider Qualifications
Physical therapy, occupational therapy and speech therapy services provided or subcontracted by a home health agency meet the service and provider qualifications pursuant to 42 CFR 440.110 (1) and (2).

Limitations
Iowa Medicaid does not cover audiology services provided by or subcontracted by a home health agency. 42 CFR 440.110(3) is not applicable to the Iowa State Plan.

Limitations (1), (2), and (3) listed below apply to physical therapy, occupational therapy and speech therapy services. Limitation (4) applies to occupational and physical therapy only. Limitation (5) applies to speech therapy only.

All limitations exclude children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions.

(1) Therapy includes coverage of initial rehabilitation instruction. Payment is made for a maximum of three visits to establish the evaluation and instruction of caregivers. Payment for supervisory shifts to monitor the therapy program shall be limited to two per month for a maximum period of 12 months.

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(2) Services must be provided primarily on an individual basis. Group therapy is payable, but total units of service in a month shall not exceed total units of individual therapy.

(3) Payment will be made for individual diagnostic or trial therapy pursuant to a plan, once per year per condition. Such service shall not exceed 12 hours per month for two months.

(4) Use of isokinetic or isotonic equipment in occupational and physical therapy is covered when normal ambulation or range of motion of a joint is affected due to bone, joint, ligament or tendon injury or due to post-surgical trauma. Only the time actually spent by the therapist in instructing the patient and assessing the patient's progress is covered.

(5) Teaching a patient to use a speech generating device is payable. The patient must show significant progress outside the therapy sessions in order for these services to be covered.

8. RESERVED

9. CLINIC SERVICES

Clinic services, as defined in 42 CFR 440.90, which are provided by a clinic which is otherwise required as a matter of state or federal law to be licensed, certified or approved to provide health care services, are covered services under Iowa Medicaid only if the clinic is so licensed, certified or approved.

Services provided by facilities which are not clinic services (as defined in 42 CFR 440.90) may be provided through the facility if provided by licensed practitioner of the healing arts whose services are otherwise covered under the Iowa Medicaid plan, where the practitioner has an employment or contractual relationship with the facility under which the facility submits the claim (Reference: 42 CFR 447.10(g)).

Covered clinic services furnished by or under the direction of a dentist must be medically necessary for the prevention, diagnosis and treatment of dental disease or injuries and are limited to one thousand ($1,000.00) per enrollee per state fiscal year (July 1 – June 30). The $1,000 limitation does not apply to preventive, diagnostic, emergent, anesthesia in conjunction with approved oral surgery codes or fabrication of dentures, and children under 21 years of age are eligible for medically necessary dental services in accordance with federal early and periodic screening, diagnostic, and treatment (EPSDT) requirements. Covered dental benefits are outlined in Dental Services. The limitations applying to dental services may be exceeded based on medical necessity.

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10. DENTAL SERVICES

Dental services, as defined in 42 CFR 440.100, are covered for children and adults and must be medically necessary for the prevention, diagnosis and treatment of dental disease or injuries. Dental services are limited to one thousand dollars ($1,000.00) per enrollee per state fiscal year (July 1 – June 30). The $1,000 limitation does not apply to the following services: preventive, diagnostic, emergent, anesthesia in conjunction with approved oral surgery codes or fabrication of dentures. The following limitations also apply to dental services but may be exceeded based on medical necessity. Children under 21 years of age are eligible for medically necessary dental services in accordance with federal early and periodic screening, diagnostic, and treatment (EPSDT) requirements.

Full Dental Benefits

A. *Preventive services.*

a. Oral prophylaxis, including necessary scaling and polishing. *Limitation:* Once in a six-month period except for persons who, because of physical or mental disability, need more frequent care.

b. Topical application of fluoride. *Limitation:* Once in a 90-day period. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants. *Limitation:* Covered on first and second deciduous and permanent molars only for children through 21 years of age and for others who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

B. *Diagnostic services.*

a. Comprehensive oral evaluation. *Limitation:* maximum of 1 every 3 years per dentist.

b. Periodic oral examination. *Limitation:* maximum of 2 per 12 months, 6 months apart.

c. Full mouth radiograph survey consisting of a minimum of 14 periapical films and bitewing films. *Limitations:* Once in a 5 year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six.

d. Supplemental bitewing films. *Limitations:* Once in a 12-month period.

e. Single periapical films, intraoral radiograph, occlusal, extraoral radiograph, posterior-anterior and lateral skull and facial bone radiograph, survey film, temporomandibular joint radiograph, and cephalometric film when medically necessary.

C. *Restorative services.*

a. Treatment of dental caries in those areas which require immediate attention. *Limitation:* Restoration of incipient or nonactive carious lesions are not covered.

b. Amalgam alloy and composite resin-type filling materials. *Limitation:* Once for the same restoration in a two-year period. An amalgam restoration is covered following a sedative filling in the same tooth only if the sedative filling was placed more than 30 days previously.

c. Stainless steel crowns are covered when a more conservative procedure would not be serviceable. *Limitation:* Stainless steel crowns with a resin window are limited to anterior teeth.

d. Laboratory fabricated crowns. Prior authorization is required. *Limitation:* Noble metals are limited to individuals who are allergic to all other restorative materials.

e. Cast post and core, post and composite or amalgam in addition to a crown. *Limitation:* Covered if a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

D. *Periodontal services.* Full mouth debridement is covered once every 24 months and is not allowed on the same date of service when prophylaxis or other periodontal services are provided. Periodontal treatment procedures require prior authorization.

E. *Endodontic services.* Covered when there is a fair to good prognosis for maintaining the tooth. Endodontic retreatment requires prior authorization.

F. *Orthodontic services.* Covered for a severe, handicapping malocclusion. Prior authorization is required. *Limitation:* Not covered for enrollees 21 years of age and over.

G. Reserved

H. *Prosthetic services.*

a. An immediate denture or a first-time complete denture including six months' post-delivery care when provided to establish masticatory function. *Limitations:* Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.

b. Removable and fixed partial dentures require prior authorization. *Limitations:* A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing

posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.

c. Replacement dentures. Limitations: Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five-year period. Prior authorization may be obtained if replacement is medically necessary prior to the expiration of the five-year period. Prior authorization is also allowed for more than one denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

d. Relines. *Limitation*: Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.

e. Tissue conditioning. *Limitation*: Covered twice per prosthesis in a 12-month period.

f. Repairs. *Limitation*: Only two repairs per prosthesis are allowed in a 12-month period.

g. Obturator. *Limitation*: For surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

h. Adjustments to a complete or removable partial denture. *Limitation*: If medically necessary after six months' post-delivery care.

I. *Implants.* Covered when a conventional denture cannot be used due to missing significant oral structures as a result of cancer, traumatic injuries, or developmental defects such as cleft palate. Prior authorization is required.

J. *Treatment in a hospital.* Covered only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

Basic Dental Benefits

As provided under the authority of section 1115 Iowa Dental Wellness Plan waiver approved

on July 27, 2017, and represents a subset of the full dental benefits listed above.

1. Periodic evaluation - *Limitation*: Maximum of 2 per 12 months, 6 months apart.
2. Comprehensive evaluation - *Limitation*: maximum of 1 every 3 years per dentist.
3. Problem focused evaluation
4. Periodontal comprehensive evaluation - *Limitation*: maximum of 1 per 12 months.
5. Oral prophylaxis, including necessary scaling and polishing - *Limitation*: Once in 6-month period except for persons who, because of physical or mental disability, need more frequent care.
6. Periodontal maintenance - *Limitation*: maximum of once every 3 months.
7. Pulp vitality test
8. Sedation
9. Tooth re-implantation/splinting
10. Incision and drainage of abscess
11. Radiographs including periapical, bitewing, and panoramic. *Limitation*: panoramic radiograph has a maximum of 1 every 5 years, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases.
12. Pulpal debridement and pulpotomy
13. Office visit after regularly scheduled hours
14. Biopsy
15. Palliative treatment of dental pain
16. Extraction and surgical removal of residual tooth roots
17. Surgical extraction, impactions
18. Caries risk assessment
19. Fluoride application
20. Interim caries arresting medicament application
21. Dentures, including repairs and adjustments, as further described in item 12b on pages 30 and 30a of Supplement 2 to Attachment 3.1-A

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11. THERAPIES

11.a PHYSICAL THERAPY

Physical therapy services and provider qualifications meet the requirements set forth in 42 CFR 440.110. Physical therapy services are covered under this item only if provided by (1) a Medicare certified rehabilitation agency, in accordance with its conditions of certification or (2) a physical therapist in private practice. Physical therapy services provided by a rehabilitation agency are subject to the limitations described in Item 7e, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions. Physical therapy services provided by a therapist in private practice are limited in amount, scope and duration under Medicare Part B as set forth in 42 CFR 410.60.

Services are covered in accordance with an active treatment plan established by the physician and provided by a licensed physical therapist within the scope of his or her practice as defined by state law and regulation referenced below. Services provided by a physical therapist include: screening, evaluation, diagnostic or trial therapy, rehabilitation, remediation and reevaluation. Services provided by a licensed physical therapist assistant must be in accordance with the established treatment plan and under the supervision of the physical therapist.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 200 (Licensure of Physical Therapists and Physical Therapy Assistants) and Chapter 201 (Practice of Physical Therapists and Physical Therapy Assistants). Physical therapist regulations stipulate graduation from a physical therapy program accredited by an approved national accreditation agency and a passing score on the National Physical Therapy Examination or other nationally recognized equivalent examination as defined by the Board of Physical and Occupational Therapy Examiners. Physical therapy assistant regulations stipulate graduation from a physical therapy assistant program accredited by an approved national accreditation agency and a passing score on the National Physical Therapy Examination or other approved nationally recognized equivalent as set forth in 42 CFR 484.4.

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11.b OCCUPATIONAL THERAPY

Occupational therapy services are covered under this item only if provided by a Medicare certified rehabilitation agency, in accordance with its conditions of certification. Occupational therapy services provided by a rehabilitation agency are subject to the limitations described in Item 7d, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions.

Services are covered when provided by a licensed occupational therapist within the scope of his or her practice as defined by state law and regulation referenced below. Services provided by an occupational therapist include: screening, evaluation, establishing a plan of care, providing appropriate treatment, determining the appropriate portions of the treatment program to be delegated to assistive personnel, appropriately supervising assistants and patient reevaluation.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 206 (Licensure of Occupational Therapists and Occupational Therapy Assistants) and Chapter 208 (Practice of Occupational Therapists and Occupational Therapy Assistants, which stipulate a degree in occupational therapy from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association and a passing score on the licensure examination for occupational therapists administered by the National Board for Certification in Occupational Therapy in compliance with 42 CFR 440.110b.

Services are covered when provided by licensed occupational therapy assistant within the scope of his or her practice as defined by state law and regulation referenced below. Covered services of an occupational therapy assistant are in accordance with the treatment plan written by the supervising occupational therapist.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 206 (Licensure of Occupational Therapists and Occupational Therapy Assistants) and Chapter 208 (Practice of Occupational Therapists and Occupational Therapy Assistants, which stipulate graduation from an educational program approved by the Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association and passing score on the licensure examination for occupational therapy assistants) as set forth in 42 CFR 484.4.

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11.c SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS

Audiology services are covered only when furnished by a qualified audiologist as defined below. Services are limited to the examination to determine the need for a hearing aid, a vibrotactile aid and vestibular testing, when prescribed by a physician. Audiology services provided by a rehabilitation agency or an audiology assistant are not covered.

Reference: Iowa Administrative Code Part 645 (Professional Licensing) – Chapter 300 (Licensure of Speech Pathologists and Audiologists), which stipulate requirements for a masters or doctoral degree for audiologists and a Certificate of Clinical Competence in Audiology granted by the American-Speech-Language Hearing Association in accordance with 42 CFR 440.110 At a minimum, an audiology assistant must be 18 years of age, a high school graduate or its equivalent and complete a three-semester-hour (or four-quarter-hour) course in introductory audiology from an accredited institution with 15 hours of instruction in the specific tasks which the assistant will be performing or have completed a minimum training period comprised of 75 clock hours on instruction and practicum experience .

Speech therapy services are covered under this item only if provided by (1) a Medicare certified rehabilitation agency, in accordance with its conditions of certification, (2) a speech pathologist enrolled in the Medicare program, or (3) a licensed speech pathologist in independent practice. Speech therapy services provided by a rehabilitation agency are subject to the limitations described in Item 7d, except for children under 21 years of age for which medically necessary services are covered in accordance with the EPSDT provisions.

Services covered include evaluation and reevaluation, therapy to restore functions affected by illness, injury, or a disabling condition resulting in communication impairment or to develop functions where deficiencies currently exist, aural rehabilitation, teaching use of an augmentative communication device, instruction of the patient and caregivers for a maintenance program. Services provided by a speech therapy assistant are not covered.

Reference: Iowa Administrative Code Part 645(Professional Licensing) – Chapter 300 (Licensure of Speech Pathologists and Audiologists, which stipulates possession of a master's degree or its equivalent, at least nine months of supervised full time clinical experience, a qualifying score on the National Teacher Examination in Speech Pathology and a certificate of clinical competence from the American Speech-Language Hearing Association) in accordance with 42 CFR 440.110c.

American Speech-Language Hearing Association) in accordance with 42 CFR 440.110c.

12.a. PRESCRIBED DRUGS – Description of Service Limitation

"Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation or prevention of disease, or for health maintenance that are –

(1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;

(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the state Medical Practice Act, and

(3) Dispensed by the licensed pharmacist or practitioner or a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

In accordance with Sections 1902(a)(54) and 1927 of the Social Security Act, the Iowa Medicaid Program covers outpatient drugs which are covered by a national or state agreement, with the following restrictions or exceptions:

A. Prior authorization program which complies with Section 1927(d)(5) of the Social Security Act.

B. Drugs are not covered if the prescribed use is not for a medically accepted indication, as defined by Section 1927(k)(6).

C. Drugs prescribed in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (DESI drugs) are excluded from coverage.

D. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

E. Except as indicated below, the Medicaid agency does not provide coverage, for any medical use or to any Medicaid recipient, of any drug or class of drugs that may be excluded pursuant to section 1927(d)(2) of the Social Security Act (hereinafter referred to as "excludable drugs").

As indicated by checkmark, the following excludable drugs are covered, to the extent indicated in parentheses, for all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D:

☐ (a). Agents when used for anorexia, weight loss or weight gain. (None)

☐ (b). Agents when used to promote fertility. (None)

☐ (c). Agents when used for cosmetic purposes or hair growth. (None)

☑ (d). Agents when used for symptomatic relief of cough and colds. (Some – select nonprescription [over-the-counter] pseudoephedrine products and dextromethorphan-guaifenesin syrup are covered.)

☑ (e). Prescription vitamins and mineral products, except prenatal vitamins and fluoride. (All – prescription vitamins and minerals that meet prior authorization requirements are covered.)

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☑ (f). Nonprescription drugs (Some - select acne preparations, analgesics, antidiarrheals/antacids, antiemetics, antihistamines, cough & cold, GI stimulants/antiflatulents, insulin, NSAIDs, ophthalmics, respiratory inhalants, topical antibiotics, topical antifungals, topical keratolytics, topical pediculicides, vaginal antifungals, and nonprescription drugs previously covered as prescription drugs).

☐ (g). Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. (None)

☐ (h). Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration. (None)

SUPPLEMENTAL MEDICAID REBATE AGREEMENT

Pursuant to Section 1927 of the Act, the state has the following policies for supplemental rebates for Medicaid.

A. CMS has authorized the state of Iowa to enter into "The Sovereign States Drug Consortium (SSDC)." A model rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid population, submitted to CMS on March 14, 2018, and entitled "Iowa Medicaid Supplemental Drug Rebate Agreement" has been authorized by CMS.

A. Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

B. Payment of supplemental rebates results in a drug being included on the preferred drug list and/or the recommended drug list.

C. Drugs of manufacturers who do not participate in the supplemental rebate program will be made available to Medicaid beneficiaries through prior authorization.

D. Supplemental rebates are for the Medicaid population only.

E. Participation in the SSDC multi-state rebate agreement will not limit the state's ability to negotiate state-specific supplemental rebate agreements.

12b. DENTURES

Dentures, including repairs and adjustments are covered under the Medicaid state plan based on medical necessity and subject to the following limitations. The denture limitations described below many be exceeded based on medical necessity and with prior authorization.

A. An immediate denture or a first-time complete denture including six months' post-delivery care when provided to establish masticatory function. Limitations: Immediate and first-time complete dentures are covered only once following the removal of teeth it replaces.

B. Removable and fixed partial dentures require prior authorization. Limitations: A missing anterior tooth must have adequate space for replacement with a partial denture. Partial dentures replacing missing posterior teeth are not covered when there are at least eight posterior teeth in occlusion. Fixed partial dentures are covered only for members who have a documented physical or mental condition that precludes the use of a removable partial denture, or who have a full denture in one arch and a fixed partial denture replacing posterior teeth is required to balance occlusion in the opposing arch.

C. Replacement dentures. Limitations: Replacement of immediate, complete, removable and fixed partial dentures requires prior authorization and is limited to once in a five-year period. Prior authorization may be obtained if replacement is medically necessary prior to the expiration of the five-year period. Prior authorization is also allowed for more than one

denture replacement per arch within five years when the member has a medical condition that necessitates thorough mastication. Replacement due to resorption is not covered.

D. Relines. Limitation: Chairside relines and laboratory processed relines are covered only once per prosthesis every 12 months.

E. Tissue conditioning. Limitation: Covered twice per prosthesis in a 12-month period.

F. Repairs. Limitation: Only two repairs per prosthesis are allowed in a 12-month period.

G. Obturator. Limitation: For surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

H. Adjustments to a complete or removable partial denture. Limitation: If medically necessary after six months' post-delivery care.

12c. PROSTHETIC DEVICES

Prosthetic devices are not covered when dispensed to a patient before the patient undergoes a procedure which will make the use of the device necessary.

The following prosthetic and orthotic devices are covered:

a. Prosthetic devices other than dental, that replace all or a part of an internal body organ, including colostomy bags and supplies, directly related to colostomy care, including-
   (i) Replacement of prosthetic devices; and
   (ii) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intralocular lens is insert.
b. Leg, arm, back and neck bracers and artificial legs, arms and eyes, including replacements if required because of a change in the individual's physical condition.
c. Durable planter foot orthotic;
d. Plaster impressions for foot orthotic;
e. Molded digital orthotic;
f. Shoe padding when appliances are not practical;

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g. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

12d. EYEGLASSES
See Limitations on eyeglasses in Section 6b (Optometry Services).

13a. RESERVED

13b. RESERVED

13c. RESERVED

13d. REHABILITATIVE SERVICES
Rehabilitative services, not otherwise covered under the Iowa State Plan, are covered if:

(1) There has been an appropriately documented diagnosis of a mental disability by a physician or other licensed practitioner of the healing arts acting within the scope of his or her practice under State law.

(2) The services are provided pursuant to an individualized plan of treatment for the individual receiving the services which plan has been recommended by a physician or other licensed practitioner of the healing arts acting with the scope of his or her practice under State law. The plan must be:
   (a) Consistent with the documented diagnosis of disability in (1) above;
   (b) Developed and documented in accordance with the standards of good medical practice; and
   (c) Time limited, or otherwise provide for periodic evaluation of the impact of the rehabilitative services provided under the plan to assure that the plan as implemented remains appropriate for the maximum reduction of the mental disability of the individual and the restoration of the individual to his or her best possible functional level.

(3) The rehabilitative services provided under the plan described in (2) above are appropriately documented by the rehabilitative services provider(s) in a manner which permits a physician or other licensed practitioner of the healing arts to determine that the plan as implemented remains appropriate for the maximum reduction of the mental disability of the individual and the restoration of the individual to his or her best possible functional level, and such a determination is periodically made and documented by a physician or other licensed practitioner of the healing arts.

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(4) The rehabilitative services are provided to, or directed exclusively toward the treatment of Medicaid eligible members.

(5) Services under Behavioral Health Intervention Services will be provided by staff who meet the following requirements: a) Community: Bachelor's degree in social science field with 1 year experience or 20 hours training in child mental health or non-social science field with 2 years' experience or 30 hours training in child mental health b) Residential: Bachelors in social science field or bachelors in non-social science field and 30 hours training in child mental health or AA degree and 1 year of child mental health experience or high school diploma/GED and 5 years of child mental health experience.

(6) Services under the Assertive Community Treatment (ACT) program.

(a) Circumstances when ACT is appropriate for members:

Assertive Community Treatment is comprehensive, integrated, and intensive outpatient services delivered in the community such as the consumer's home or residence and/or other community settings to a Medicaid eligible person from a multidisciplinary team. These services are directed toward the rehabilitation of behavioral/social/emotional deficits and/or amelioration of symptoms of mental disorder. Such services are directed to consumers with severe and persistent mental disorders (SPMI), and/or complex symptomatology which require multiple mental health and support services to reduce hospitalizations. Such services are active and rehabilitative in focus, and are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the client's functioning and assisting them in achieving community tenure. The ACT Team shall participate in all mental health services provided to consumers and provide 24 hour service for the psychiatric needs of the member. Each consumer shall have a written treatment plan containing the necessary psychiatric rehabilitation treatment and support services as well as a crisis plan. The plan shall include treatment objectives and outcomes, the expected frequency and duration of each service, where the services are provided, a work evaluation, and the schedule for updates of the plan.

The ACT program is for persons who need a consistent team of professionals to provide care in the community and have a validated diagnosis consistent with a serious and persistent mental illness. Diagnosis of primary substance disorder, developmental disability, or organic disorders are excluded. Level of stability (must meet 1 or 2, and all of 3, 4, and 5):

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1. A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months.
2. The client is in need of multiple and/or combined mental health and basic living supports to prevent need for more intrusive level of care.
3. Risk to self, others, or property is considered to be low (although without treatment or support the client's potential risk in these areas may be increased).
4. The client is medically stable and does not require a level of care that includes more intensive medical monitoring.
5. The client lives independently in the community or demonstrates a capacity to live independently and transform from a dependent residential setting to independent living.

Degree of impairment (must meet 1 and 2 and may meet 3):

1. Client does not have the resources or skills necessary to maintain an adequate level of functioning in the home environment without assistance or support and exhibits impairments arising from a psychiatric disorder which compromises his/her judgment, impulse control and/or cognitive perceptual abilities.
2. Social/interpersonal/familial: Client exhibits significant impairment in social, interpersonal or familial functioning arising from a psychiatric disorder which indicates a need for assertive treatment to stabilize or reverse the condition.
3. Vocational/educational: Client exhibits impairment in occupation or educational functioning arising from a psychiatric disorder which indicates a need for counseling, training or rehabilitation services or support to stabilize or reverse the condition.

(b) Available services under the ACT program:

1. Evaluation and medication management: Providing a comprehensive mental health evaluation. Medication management consists of a professional with medical training (psychiatrist/ARNP/PA) prescribing medications and managing the process to respond to client complaints/symptoms. The psychiatric registered nurse assists in this management by contact with the client on medications and their effect on the clients' complaints/symptoms. Provider types providing this service are: psychiatrist, registered nurse, and ARNP/PA.
2. Integrated therapy and counseling for mental health and substance abuse: Direct counseling for treatment of mental health and substance abuse symptoms. Provider types providing this service are: psychiatrist, licensed mental health professional, ARNP/PA.
3. Skill teaching: Side by side demonstration and observation of daily living tasks. Provider types providing this service are: registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, and ARNP/PA

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4. Community support: The ACT team will deliver services that are recovery and rehabilitative focused. These services consist of:

   a. Personal and home skill training services to assist the member to restore skills for self-directedness and coping with the living situation.

   b. Community skills training services to assist the person in restoring a positive level of participation in the community and maximizing utilization of appropriate socialization skills and personal coping skills. Provider types providing this service are: licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, and ARNP/PA.

5. Medication monitoring services designed to control symptoms of mental illness, asking questions of the client and making observations concerning medication compliance and access to medications as well as assuring appointments are kept and day-to-day functioning is assessed. Provider types providing this service are: psychiatric nurses and other team members under the supervision of psychiatrist/nurse.

6. Care management is provided by ACT staff for treatment and service plan coordination. Development of an individualized treatment and service plan including personalized goals and outcomes developed by the ACT team to diagnosis, treat, and rehabilitate the client's medical symptoms and remedial functional impairments. The care management includes assessments, referrals, follow-up, and monitoring, in addition to assisting members in gaining access to necessary medical, social, educational, and other services. Care management includes the assessing the member in coordination with other ACT team members to determine service needs by collecting relevant historical information through member records and gathering other information from relevant professionals and natural supports. The care management will develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services. The care management will also make referrals to services and related activities to assist the member with their assessed needs, monitor and perform follow up activities necessary to ensure the plan is carried out and the member has access to necessary services within the framework of the ACT team. This can include monitoring contacts with providers, family members, natural supports, and others. Last the ACT team will hold daily team meetings to coordinate each client's care with other members of the team.

7. Crisis response: ACT crisis response service includes direct assessment and treatment of urgent/crisis symptoms in the community. Provider types providing this service are: registered nurse, licensed mental health professional, substance abuse counselor, community support specialist, and ARNP/PA. The psychiatrist and licensed mental health professionals (e.g., registered nurse, licensed mental health professional, substance abuse counselor, and ARNP/PA) provide the assessment. The ARNP/PA's are optional but can perform functions similar to the psychiatrist. The team is responsible for the development of the treatment plan. Crisis response team requires a combination of the provider types listed. Treatment of urgent/crisis symptoms in the community can be provided by all team members. Case management is a team function rather than a staff position. All team members can perform crisis response services under the supervision of the psychiatrist. The psychiatrist may provide supervision in person or on the telephone.

8. Work-related services: Assisting client in managing mental health symptoms as they relate to job performance. Collaborating with client to look for areas of the job which may cause symptoms to increase and create strategies to manage these situations. Restore skills toward placement such as individual work-related behavioral management. Providing supports to maintain employment such as crisis intervention related to employment and skills for coping with employment demands. Assisting in use of skills such as communication skills, problem solving, and safety. Restoring personal skills such as time management and appropriate grooming for employment. Provider types providing this service are: registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, and ARNP/PA.

(c) Providers of ACT services. All provider types are clinically supervised by the psychiatrist.

1. Psychiatrist: An MD or DO board eligible with SPMI experience who is responsible for clinical supervision of the team. Licensure per 653 Iowa Administrative Code Chapter 9 and certified by the American Board of Psychiatry and Neurology.

2. Registered nurse: Registered in Iowa with serious and persistent mental illness (SPMI) experience. Licensure per 655 Iowa Administrative Code Chapter 3.

3. Licensed mental health professional: Licensed in Iowa with SPMI experience Master's level. Licensure according to 441 Iowa Administrative Code Chapter 24, Mental Health Professional. This person is usually the team leader, responsible for administrative supervision.

4. Psychologist: Licensed in Iowa having experience with persons with SPMI. Licensure per 645 Iowa Administrative Code 240.

5. Substance abuse counselor: Iowa or national certification as substance abuse counselor and three years substance abuse experience required. Iowa certification per 641 Iowa Administrative Code 155.21(8)i.

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6. Peer specialist: Certified peer specialists are self-identified consumers who are in recovery from mental illness and/or substance use disorders and will work under the supervision of a competent mental health professional including all licensed professionals. Peer specialists provide specific support within the overall clinical treatment plan developed by the ACT team. They demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders by meeting all the requirements of the "Peer Support Training Academy" requiring 30 hours of training and passing the exam.
7. Community support specialist: BA/BS in human services (sociology, social work, counseling, psychology or human services) with SPMI experience.
8. Case manager: BA/BS in human services with SPMI experience. Meets the qualifications of "qualified case managers and supervisors" in 441 Iowa Administrative Code Chapter 24.
9. Advanced registered nurse practitioner/physician assistant (ARNP/PA): Licensed in their area of practice and experience with SPMI. Licensure of advanced registered nurses per 655 Iowa Administrative Code Chapter 7. Licensure of physician assistants per 645 Iowa Administrative Code Chapter 326.

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(6) Behavioral Health Intervention Services (BHIS)

(a) Services under Behavioral Health Intervention Services (BHIS) are interventions that ameliorate behaviors and symptoms associated with a psychological disorder that has been assessed and diagnosed by a licensed practitioner of the healing arts within the scope of their practice under State law. The services must be medically necessary and be:
   i. Consistent with the diagnosis and treatment of the member's condition and specific to an impairment,
   ii. Required to meet the medical needs of the member
   iii. In accordance with the standards of evidence-based medical practice.
   iv. The services are designed to address the symptoms and psychological needs of persons with a psychological disorder for maximum reduction of mental health impairment and restoration of a member to the best possible functional level.
   v. Services are directed exclusively to the treatment of the Medicaid-eligible individual.

(b) BHIS behavioral health intervention services are community intervention services that focus on
   1)Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life.
   2)Improving or managing a member's health and well-being related to the member's impairment and
   3) Increasing a member's ability to manage mental health symptoms.

(c) The service is not covered for beneficiaries who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.
(d) The focus of the intervention is to improve the member's health and well-being using cognitive, behavioral, or social interventions designed to ameliorate diagnosis-related issues.
(e) Limits on service are based on the medical necessity of the member.
(f) The agencies that can provide BHIS services are organizations that are credentialed as:
   i. Other Mental Health Provider or Community Mental Health Center, or
   ii. National accredited provider for mental health rehabilitative skill-based interventions by the Joint Commission, Council on Accreditation, or Commission on Accreditation of Rehabilitation facilities, or
   iii. Licensed residential group care, or
   iv. Licensed Psychiatric Medical Institution for Children, or
   v. Other organizations that participate in a site visit and meet minimum credentialing standards
(g) Supervision of the community BHIS services will be provided for 4 hours per month by a licensed, master's level prepared mental health practitioner and residential BHIS will be provided for 4 hours per month by a licensed, masters level prepared mental health practitioner or a person with a bachelor's degree and five years or more of child mental health service experience. Licensed mental health practitioners include licensed social workers, martial and family therapists, mental health counselors, psychologist, ARNPs and physicians.

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BHIS Practitioners	Minimum Level of Education / Degree / Experience Required	License / Certification Required	Clinical Supervision
Practitioners rendering Behavioral Intervention Services, Crisis Services, and Community Intervention Services abide by the same requirements	Bachelor's degree in social sciences field, or Bachelor's degree in non-social science field plus 30 hours in child mental health training or AA degree in social sciences field plus one year experience in child mental health services or High school diploma or GED plus a minimum of five years of child mental health experience	None	Licensed, Masters level prepared mental health practitioner (e.g. licensed social workers, marital & family therapists, mental health counselors, psychologists, ARNPs, and physicians) or Bachelor's degree with five years or more of child mental health service experience.

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BHIS Service	Services Description	Qualified Rendering Practitioners
Behavioral Intervention services (includes individual, group, and family services.)	Services designed to modify the psychological, behavioral, emotional, cognitive, and social factors impacting a member's functioning. Interventions may address the following skills for effective functioning: cognitive flexibility, communication, conflict resolution, emotional regulation, interpersonal relationship, problem-solving, and social skills. The intervention may be provided in an individual, family, or group format.	See prior table
Crisis Intervention services	Focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The services shall be designed to de-escalate situations in which a risk to self, others, or property exists.	See prior table
Community Intervention Services	Service includes interventions to enhance independent living, social and communication skills that minimize or eliminate psychological barriers to a member's ability to manage symptoms associated with a psychological disorder effectively and maximize the individual's ability to live and participate in the community.	See prior table

(7). *Drug & alcohol services*. The services include mental health assessment (Assess client's current situation, determine client's immediate needs, screen for physical, medical, and co-occurring disorders, and develop a comprehensive written summary), counseling, and intervention (The focus of the counseling or intervention is to improve the patients' health and well-being utilizing cognitive, behavioral, social and or psychophysiological procedures.) Services are provided by a person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor. Practitioner qualifications are referenced in Iowa Administrative Code 641-155. Qualifications include a high school diploma or general education diploma and 150 clock hours of training in the alcohol and drug counselor knowledge and skill competencies. One and a half years full-time (or 3,000 clock hours) of supervised experience is required.

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14a. RESERVED

14b. RESERVED

15a. ICF/MR SERVICES WHICH ARE NOT IN PUBLIC INSTITUTIONS

ICF/MR services must be ordered by a physician, skilled in the diagnosis and treatment of mental retardation, or other licensed practitioner of the healing arts, skilled in the diagnosis and treatment of mental retardation and acting within the scope of his or her practice who is who has either (1) identified to recipient or his representative alternatives to placement in an ICF/MR and provided guidance on how to access such alternatives, or (2) documented in the recipient's clinical record why the identification of alternatives was determined unnecessary or inappropriate.

ICF/MR services must also be provided under the direction of a physician.

15b. ICF\MR SERVICES WHICH ARE IN PUBLIC INSTITUTIONS

ICF/MR services must be ordered by a physician, skilled in the diagnosis and treatment of mental retardation, or other licensed practitioner of the healing arts, skilled in the diagnosis and treatment of mental retardation and acting within the scope of his or her practice who is who has either (1) identified to recipient or his representative alternatives to placement in an ICF/MR and provided guidance on how to access such alternatives, or (2) documented in the recipient's clinical record why the identification of alternatives was determined unnecessary or inappropriate.

ICF/MR services must also be provided under the direction of a physician.

16. RESERVED

17. RESERVED

18. RESERVED

19. Tuberculosis Services are not provided

20. RESERVED

21. RESERVED

22. RESERVED

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23 NURSE PRACTITIONERS

Coverage under this item is limited to services provided by advanced registered nurse practitioners practicing within their scope of practice under State law and in a specialty area recognized under applicable Iowa Board of Nursing rules. Services that are otherwise not payable to physicians under this State Plan are also not payable to nurse practitioners. Nurse practitioner services are covered consistent with *definitions under 42 CFR 440.166(a) and further described in Section 4415 (Nurse Practitioner Services) of the State Medicaid Manual and in compliance with the requirements in 42 CFR 441.22, are provided with additional limitations described in Attachment 3.1-A(22). (For methods and standards for payment rates see Attachment 4.19-B(23).*

24a. TRANSPORTATION

Ambulance Service. Ambulance service under Medicaid is the same as Medicare Part B ambulance coverage under 42 CFR 410.40 except that the following services are not covered under Iowa Medicaid:

(1) Emergency Ambulance transportation of a hospital inpatient throughout the period in which the individual remains an inpatient of the same hospital.

(2) The services of more than one ambulance provider for a patient for the same transport.

Emergency Ambulance service coverage is subject to Medicare guidelines with the following exceptions:

- When an ambulance service provides transport of a hospital inpatient to a provider and returns the patient to the same hospital (i.e., the patient continues to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement, instead of fiscal agent, since the hospital's DRG reimbursement system includes all costs associated with providing inpatient services.
- In the event that more than one ambulance service is called to provide ground transportation, payment shall be made to one ambulance company.

(3) Non-emergency Ambulance service may be provided under the NEMT brokerage system when necessary to meet the medical needs of the member.

Non-emergency Transportation. Non-emergency transportation is provided through a brokerage as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4). The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR92.36(b)-(i).

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order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR92.36(b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

_(1) state-wideness (indicate areas of State that are covered)

_(10)(B) comparability (indicate participating beneficiary groups)

X (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

X wheelchair van

X taxi

X stretcher car

X bus passes

X tickets

_ secured transportation

X other transportation (Multiple-passenger van, sedans, gas reimbursement for Members/individuals/volunteers, fixed wing flights)

(3) The State assures that transportation services will be provided under contract with a broker who:

i. Is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualification, and costs:

ii. Has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

iii. Is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

iv. Complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on

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v. physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

X Low-income families with children (section 1931)

X Deemed AFCD-related eligibles

X Poverty-level related pregnant women

X Poverty-level infants

X Poverty-level children 1 through 5

X Poverty-level children 6 – 18

X Qualified pregnant women AFDC – related

X Qualified children AFDC – related

X IV-E foster care and adoption assistance children

X TMA recipients (due to employment) (section 1925)

X TMA recipients (due to child support)

X SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

X Optional poverty-level - related pregnant women

X Optional poverty-level - related infants

X Optional targeted low income children

X Non IV-E children who are under State adoption assistance agreements

X Non IV-E independent foster care adolescents who were in foster care on their 18th birthday

X Individuals who meet income and resource requirements of AFDC or SSI

_ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency

_ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law

_ Children aged 15-20 who meet AFDC income and resource requirements

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X Individuals who would be eligible for AFDC or SSI if they were not in a medical institution

_ Individuals infected with TB

X Individuals screened for breast or cervical cancer by CDC program

_ Individuals receiving COBRA continuation benefits

X Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

X Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution

_ Individuals terminally ill if in a medical institution and will receive hospice Care

_ Individuals aged or disabled with income not above 100% FPL

_ Individuals receiving only an optional State supplement in a 209(b) State

X Individuals working disabled who buy into Medicaid (BBA working disabled group)

X Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group

_ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

X (i) risk capitation

_ (ii) non-risk capitation

_ (iii) other (e.g., brokerage fee and direct payment to providers)

(B) Who will pay the transportation provider?

X (i) Broker

_ (ii) State

_ (iii) other

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The broker will arrange and reimburse for the most economical form of transportation appropriate to the needs of the member. The broker is responsible for reimbursing all NEMT providers and Members/individuals/volunteers, including claims for mileage, meals, and lodging for the Member and an attendant and/or parent/guardian if necessary. As part of this responsibility, the broker must comply with all state and federal tax reporting laws.

(C) What is the source of the non-Federal share of the transportation payments?

The source of the non-Federal share of the transportation payments will primarily be funded by appropriations from the Legislature, which would include appropriations from Iowa's General Fund account, as well as several other funds. In addition, the non-Federal share of MEPD premium collections, TPL collections, estate recoveries, and other recoveries (such as overpayment recoveries) are deposited into the Medicaid account to offset general Medicaid spending. These revenues would also be used to fund the non-Federal share of transportation payments. The appropriation by the Legislature results in being an amount that is net of these credits to the Medicaid account.

(D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

(7) The broker is a non-governmental entity:

X The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

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i. ☐ transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker

ii. ☐ transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

iii. ☐ the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

iv.

(8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

(9) Please describe how the NEMT brokerage program operates.

Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, is provided through the broker designated by the department pursuant to a contract between the department and the broker.

The State issued an RFP on 02/25/2010, to establish a statewide broker for the provision of nonemergency medical transportation (NEMT). Iowa received five bid proposals that were reviewed based on objective analysis in a comparative assessment of the proposals. For the technical portion, bidders were evaluated on their executive summary, overall project understanding, general requirements, contractor responsibilities, corporate/team experience and qualifications. Cost proposals were also reviewed and ranked. These two scores were then added together for a final score.

Medicaid Members eligible for NEMT services are those who are eligible for Medicaid under a federal aid category on the date the transportation is provided. The State's MMIS contractor makes

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eligibility information available to the broker on a daily basis. When a member needs nonemergency medical transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker has established and publicized the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

Transportation is provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

Transportation is provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available and payment for transportation to obtain prescribed drugs shall be reimbursed when the prescribed drug is needed immediately, or when the pharmacy provides free delivery but is unable to deliver the medication in a timely fashion that meets the medical needs of the patient.

Transportation beyond 20 miles (one way) is provided only to the closest qualified provider unless:

a) The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or
b) The additional cost of transportation to the provider requested by the member is medically justified based on:
   1. A previous relationship between the member and the requested provider,
   2. Prior experience of the member with closer providers, or
   3. Special expertise or experience of the requested provider.

Exceptions for nursing facility residents. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) will not be provided through the broker but will be the responsibility of the nursing facility. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) will be provided through the broker, but the nursing facility will contact the broker on behalf of the resident.

The broker maintains a toll free telephone line to accept NEMT requests from recipients. Based on the information obtained on the call, the broker will assure all NEMT criteria is met and arrange the least expensive method of transport that meets the needs of the Member. The call center has sufficient staff to perform functions for at least nine (9) consecutive hours (8:00am – 5:00pm) Monday through Friday, i.e., "normal business hours." The broker has an answering service or specified Call Center staff on duty after 5:00 pm and before 8:00 am Monday through Friday and 24 hours per day on weekends and holidays. Calls accepted after normal business hours are to schedule urgent care trips or hospital discharge trips.

Interpreter services will be available, as necessary, to ensure Members are able to communicate with the broker. Customer service policies and procedures have been implemented to address call wait time, call abandonment, and call tracking.

The broker authorizes and arranges the least expensive and most economical form of transportation appropriate to the needs of the member. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use. For children under the age of 21 or for adults with restrictive disabilities, an attendant and/or parent/guardian may accompany the member if necessary.

The broker maintains a provider network which consists of various modalities to support the transportation needs of the Members statewide. The broker ensures the safety of all Members while being transported.

All drivers:

a. Must possess a current valid driver's license with no restrictions other than corrective lenses.
b. Must have no limitation or restrictions that would interfere with safe driving. This includes, but not limited to, medical conditions, ignition interlock restriction, or prescribed medication that would interfere with the safe, lawful operation of a motor vehicle.
c. Must pass a pre-employment drug screening.
d. Must pass a Department of Criminal Investigation (DCI) background check prior to the start of employment, if required to do so by the Network transportation provider.
e. Must pass a child and dependent adult abuse background check, if required to do so by the Network transportation provider.
f. Any provider (both individual and entity) identified on the Office of Inspector General (OIG) Excluded Parties List System (EPLS) is not eligible.
g. Must be trained in the use of ADA access equipment, if vehicle is so equipped.
h. Must use passenger restraint devices as required by law.
i. Must provide assistance to passengers, as needed or requested, particularly for passengers with mobility impairments requiring assistance in boarding, deboarding, or securing a mobility device.
j. Must not smoke while transporting Members.
k. Must not transport Members while under the influence of alcohol or any drug that impairs the ability to drive safely.
l. Must not provide transportation if they have an illness that could pose a threat to the
m. health and well being of the Member.
n. Must submit to random drug and alcohol screenings, if required to do so by the Network transportation provider.

All vehicles:

a. Must currently be licensed and registered as required by law.
b. Must have proof of financial responsibility maintained on any vehicle used to transport Iowa Medicaid Members as required by law. The Broker shall confirm compliance with applicable

c. financial responsibility and/or insurance requirements, which may include Iowa Code chapter 321A, and 761 IAC 910.5(1).
d. Must be kept at all times in proper physical and mechanical condition.
e. Must be equipped with operable passenger restraint devices, turn signals, lights, horn, brakes, a front windshield, windows, and mirrors.
f. Must pass a safety inspection, if required to do so by state or federal law.
g. Must carry equipment for two-way emergency communication (two-way radio or cell phone acceptable).

As an annual performance standard, the broker must verify annually and have documentation to support, that each network provider is following the "Standard Driver and Standard Vehicle Guidelines."

The broker has established an internal inquiry, grievance, and appeal process for both transportation provider and Members, which has been approved by the State. Members may request a State Fair Hearing at any point in the grievance or appeals process. The timeline set for State Fair Hearings is adhered to and the broker complies with decisions reached by the State Fair Hearing process.

The broker provides appropriate and timely written notice to the Member/Provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested or agreed upon.

The broker's notice of decision explains:
a. the action the Broker has taken or intends to take and the reason(s) for the action;
b. the Member's or Provider's right to grieve, complain, or request a State Fair Hearing;
c. circumstances under which expedited resolution is available and how to request it;
d. that during the state fair hearing, the Member/Provider may represent him(her)self or use legal counsel, a relative, a friend, or a spokesperson;
e. the specific regulations that support, or the change in federal or state law that requires, the action,
f. the Broker in conjunction with DHS shall identify the non-English languages prevalent (i.e., spoken by a significant number or percentage of the Member's and potential population);
g. the Broker must make available written information in each prevalent non-English language;
h. That the Broker must make oral interpretation services available for all languages free of charge, and
i. That the Broker must notify Members that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.

The broker has implemented internal controls, policies, and procedures to prevent, detect, and review and report to the Medicaid State Agency instances of suspected fraud and abuse by providers, subcontractors, and Members.

State/Territory: IOWA

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(f).

The State will provide oversight and monitor the broker through weekly or bi-weekly meeting(s). The broker must meet also the performance standards that are identified in the NEMT RFP. The broker is required to provide a monthly report to the State by the tenth business day of the month following the last day of each month.

24b. RESERVED

24c. RESERVED

24d. RESERVED

24e. RESERVED

24f. RESERVED

State/Territory: IOWA

25. RESERVED

26. RESERVED

27. RESERVED

28. RESERVED

Revised Submission 3.25.10

State Plan under Title XIX of the Social Security Act
State/Territory: IOWA

TARGETED CASE MANAGEMENT SERVICES
Target Group 1

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Adults with chronic mental illness (CMI), and severely emotionally disturbed (SED) children receiving services through the HCBS Children's Mental Health waiver.

Persons eligible for targeted case management services in this target group are adults (age 18 or older) that have a diagnosis of chronic mental illness, and children (age 17 or under) eligible for the HCBS Children's Mental Health waiver. They have functional limitations and lack the ability to independently access and sustain involvement in necessary services.

Chronic mental illness means the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

Persons with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness. Persons with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

Serious Emotional Disturbance means a diagnosable mental, behavioral, or emotional disorder that:

1. Is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and
2. Has resulted in a functional impairment that substantially interferes with or limits the person's role or functioning in family, school, or community activities.

Serious emotional disturbance does not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

Revised Submission 2.6.14

State Plan under Title XIX of the Social Security Act
State/Territory: IOWA

TARGETED CASE MANAGEMENT SERVICES
Target Group 1

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
__ Entire State
_X__ Only in the following geographic areas:

Effective January 1, 2014, all counties except Polk Warren Dubuque Linn, and Woodbury counties.

Effective October 1, 2014 all counties except Polk Warren Dubuque Linn, Woodbury, and Benton Black Hawk Buchanan Calhoun Cedar Cerro Gordo Clinton Delaware Floyd Grundy Hancock Harrison Humboldt Iowa Jackson Johnson Jones Kossuth Mills Mitchell Muscatine Pocahontas Pottawattamie Scott Webster Winnebago Worth and Wright counties

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
_X_ Services are provided in accordance with §1902(a)(10)(B) of the Act.
___ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - A face-to-face assessment must be conducted at a minimum annually and more frequently if changes occur in the individual's condition.
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

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TARGETED CASE MANAGEMENT SERVICES
Target Group 1

- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group 1

- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Case management contacts shall occur as frequently as necessary, but shall consist of no less than one contact per month and must include at least one face-to-face contact with the individual every three months. Contact may be face-to-face, by telephone, or by written communication.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case management services will be provided by the Iowa Department of Human Services, by a county, or by a consortium of counties. Providers may subcontract for the provision of case management services. All providers, including subcontractors, must be accredited under Iowa Administrative Code 441- Chapter 24, which includes the following qualifications for individuals providing case management:
- A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired to serve; or
- An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired to serve.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group 1

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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TARGETED CASE MANAGEMENT SERVICES
Target Group 1

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Target Group 2

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Persons with a developmental disability, including mental retardation.

Persons eligible for targeted case management services in this target group have a primary diagnosis of mental retardation or developmental disability. They have functional limitations and lack the ability to independently access and sustain involvement in necessary services. This target group does not include persons residing in an ICF-MR.

Developmental Disability means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Mental Retardation means a diagnosis of mental retardation which:

1. Is made only when the onset of the person's condition was before the age of 18 years;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills; and
4. Is made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
X Services are provided in accordance with §1902(a)(10)(B) of the Act.
___ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to

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TARGETED CASE MANAGEMENT SERVICES
Target Group 2

needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - A face-to-face assessment must be conducted at a minimum annually and more frequently if changes occur in the individual's condition.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Case management contacts shall occur as frequently as necessary, but shall consist of no less than one contact per month and must include at least one face-to-face contact with the individual every three months. Contact may be face-to-face, by telephone, or by written communication.

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TARGETED CASE MANAGEMENT SERVICES
Target Group 2

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case management services will be provided by the Iowa Department of Human Services, by a county, or by a consortium of counties. Providers may subcontract for the provision of case management services. All providers, including subcontractors, must be accredited under Iowa Administrative Code 441- Chapter 24, which includes the following qualifications for individuals providing case management:

- A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired to serve; or
- An Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired to serve.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

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TARGETED CASE MANAGEMENT SERVICES
Target Group 2

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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TARGETED CASE MANAGEMENT SERVICES
Target Group 3

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
Children from birth to age three who meet the "developmental delay" eligibility categories set forth in the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA).

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - A face-to-face assessment must be conducted every 6 months at a minimum, and more frequently if changes occur in the individual's condition.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

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TARGETED CASE MANAGEMENT SERVICES
Target Group 3

- identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. A face-to-face contact between the case manager and the child and family is required within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact with the family is required.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Case management services will be provided by:
- A person who has been determined to meet the qualifications in Iowa Administrative Code 281—19(8):

  The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as service coordination responsibilities and strategies. The competency-based program, approved by the Department of Education, shall include different training formats and differentiated training to reflect the background and knowledge of the trainees, including those persons who are state-licensed professionals whose scope of practice includes service

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Target Group 3

coordination. The Department of Education or its designee shall determine whether service coordinators have successfully completed the training.

- A case management provider accredited pursuant to Iowa Administrative Code 441—Chapter 24.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The

State/Territory: IOWA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Iowa

CASE MANAGEMENT SERVICES

A. Target Group 5:

Children from age 3 to age 21 who meet the eligibility categories set forth in the federal regulations under Part B of the Individuals with Disabilities Education Act (IDEA).

B. Areas of the state in which services will be provided:

Entire State

C. Comparability of Services

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:
Service coordination means those case management services that will assist children who have or are suspected of having disabilities in gaining access to assessment, evaluations, and the services in the individualized education program (IEP), including:

- Administrative, directive, and monitoring services are included as part of the ongoing service coordination. These are rendered after implementing an IEP. At least one face-to-face contact with the child must be completed every 90 days. Ongoing service coordination includes:
  - Acting as a central point of contact relating to the IEP.
  - Maintaining contact with the direct service providers and with the child and family.
  - Assisting the child in gaining access to services specified in the IEP and developing linkages with service providers.

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- Reviewing with the service providers the effectiveness of the services, coordinating the service delivery, identifying obstacles to a child's receipt of services, and determining whether the services meet the child's needs.

- Providing the child and family with information and direction that will assist them in successfully accessing and using the services recommended in the IEP.
- Informing the family of the child's rights and responsibilities in regard to specific programs and resources recommended in the IEP.

E. Qualifications of Providers
A provider of service coordination shall be:

- An individual employed or under contract to a local education agency.
- Chosen considering the primary disability of the child, the child's needs, and the services recommended in the IEP.
- Appropriately licensed or certified. This could include:
  - An audiologist
  - A behavior disorders special education
  - A dietitian
  - A guidance counselor
  - A nurse
  - An occupational therapist
  - An orientation and mobility specialist
  - A physical therapist
  - A psychologist
  - A speech-language therapist
  - A social worker

F. The state assures that the provision of case management services will not restrict an individual" free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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PACE SERVICES

__X__ The State of Iowa has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

_____ The State of _____ has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary, as follows.

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: _____

(This information should be provided for all PACE providers with which the State Administering Agency for PACE and the Secretary have entered into valid program agreements.)