MINUTES
Health Policy Oversight Committee

Monday, December 21, 2020

MEMBERS PRESENT

Senator Mariannette Miller-Meeks, Co-chairperson
Senator Mark Costello
Senator Jeff Edler
Senator Liz Mathis
Senator Amanda Ragan
Representative Joel Fry, Co-chairperson
Representative John Forbes
Representative Shannon Lundgren
Representative Ann Meyer

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I. Procedural Business

The first meeting of the Health Policy Oversight Committee of the 2020 Legislative Interim was called to order on December 21, 2020, at 9:00 a.m. and adjourned at 11:04 a.m. The meeting was held by videoconference.

II. COVID-19 Impact and Medicaid Response

Ms. Julie Lovelady, Interim Medicaid Director, Department of Human Services (DHS), reviewed Iowa's Medicaid COVID-19 response. Ms. Lovelady praised the efforts of state agencies, providers, and others in working to support the Medicaid program during the pandemic.

In an effort to introduce more of the members of the DHS team, Ms. Lovelady said that various team members would be presenting during the meeting.

A. Member Response

Flexibilities During the Pandemic. Ms. Jennifer Steenblock, Medicaid federal compliance officer, DHS, spoke specifically about the flexibilities put in place to support Medicaid members and providers during the pandemic. Iowa Medicaid received approval from the Centers for Medicare and Medicaid Services (CMS) for several waivers and state plan amendments to ensure continuous and expanded services for Medicaid members during the pandemic. CMS also issued blanket waivers and rules for all states to provide flexibility. These flexibilities will be in place through at least the end of the federal public health emergency (PHE), which currently is set to expire January 22, 2021.

Since March 2020, no Medicaid member has been disenrolled or has had their services reduced and this will also continue through the end of the PHE. Additionally, all member copays, contributions, and premiums have been waived through the duration of the PHE for the Iowa health and wellness plan, the hawk-i program, and the Medicaid Employed Persons with Disabilities program. If a member pays any of these automatically during the period of the waiver, the payment is refunded.

Uninsured individuals who wish to be tested for COVID-19 may apply on the DHS website for medical coverage to cover the costs of testing. This coverage only covers the costs of the medical test for COVID-19, but does not cover other medical costs or the vaccine.

Telehealth. In March, Iowa Medicaid expanded telehealth services to allow all providers to utilize telehealth from any location when clinically appropriate and necessary to preserve the health and safety of Medicaid members. Providers must practice within their scope of practice and document the telehealth provided. These measures will be in place until at least the end of the PHE. DHS is working with the managed care organizations (MCOs) to determine what telehealth measures should be continued post-pandemic and to align with federal Medicare and Medicaid provisions. All telehealth services are currently paid based on parity with face-to-face visits. One modality that members are supporting is using audio-only telehealth going forward.

Expansion of Other Services. Prior to the pandemic, home-delivered meals and homemaker services were only available to certain members receiving home and community-based services (HCBS) waiver services. In response to COVID-19, DHS expanded home-delivered meals and homemaker services to all current members receiving HCBS waiver services or habilitation services and Medicaid members who are homebound due to COVID-19.

Additionally, companion services were only available as an alternative to replace habilitation, supported community living, or consumer-directed attendant care (CDAC) services that were unavailable when a member had a support need. In response to COVID-19, companion services were also expanded to all

current members receiving HCBS or habilitation services and Medicaid members who are homebound due to COVID-19.

Prior Authorization (PA). PAs for Medicaid members were not waived during the pandemic, nor were PAs extended for continuity of care. Instead, DHS extended PAs that were approved by the MCOs, dental plans, or DHS for fee-for-service (FFS), for elective procedures that were delayed or canceled in March through May due to COVID-19. Federal approval was not required for this change.

B. Provider Response

DHS has been dedicated to promptly answering questions from providers regarding changes and flexibilities in the Medicaid program during the PHE. The questions and answers are posted on the DHS website and are updated daily. DHS created a COVID-19 frequently asked questions (FAQ) provider toolkit, created a dedicated email address where providers can continue to send questions, and initially held weekly, and now holds periodic, calls with providers. These calls will continue during the unwinding of the PHE and post-pandemic.

Timely Filings. Prior to COVID-19, providers had 180 days to submit first-time claims. Effective with dates of service beginning April 1, 2020, providers have 270 calendar days from the date of service to submit first-time claims and encounters for managed care. For FFS and dental claims, timely filing is 365 days and remains unchanged. After the pandemic, DHS will return to normal billing guidelines. These changes were not subject to federal approval.

Civil Monetary Penalties Grant for Nursing Facilities. Nursing facilities (NFs) can apply for grants to purchase communicative technology devices for residents to use or for funds for in-person visitation aids during the PHE. The amount of a grant is up to $3,000 per facility for each type of grant, based on receipts submitted by the facility to DHS. A facility may apply for both grants, and applications will be accepted through the end of the PHE.

Retainer Payments. HCBS and habilitation providers were able to bill the MCOs for retainer payments for certain services the providers were unable to render during the month of April 2020. The retainer payments were allowed when a member was unable to receive normally authorized and scheduled services or due to closure of the provider's service lines related to COVID-19. The retainer payments were based on an average month of service pre-COVID-19.

Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Relief Grants for HCBS, Mental Health (MH) and Substance Use Disorder (SUD) Providers. DHS distributed $50 million in CARES Act grants to HCBS waiver and habilitation direct service providers, MH providers, and SUD providers to help offset impacts of the COVID-19 pandemic. Of the $50 million distributed, $30 million was distributed to HCBS waiver providers, $10 million was distributed to MH providers, and $10 million was distributed to SUD providers. Eligible providers could apply online and DHS issued payments to providers based on the respective provider's claims data from state fiscal year 2019.

Enhanced Dental Payments. DHS allowed a temporary enhanced payment to dental providers and orthodontists to help address facility and safety upgrades. Funding was provided for claims with dates of service between May 1 and August 31, 2020. The payment was an additional $8 per member, per date of service for dental wellness plan, the hawk-i program, and Medicaid FFS dental claims.

COVID-19 Relief Rate (CRR) Add-on Payment. CRR payments are available to Medicaid-certified skilled nursing facilities and NFs during the PHE to provide financial assistance to facilities that incur unexpected costs when caring for Medicaid members who are diagnosed with or in isolation (not quarantined as incorrectly stated in the handout) for potential COVID-19. The facility must have a designated isolation unit for the treatment of COVID-19 or the facility in its entirety must be designated

for treatment of COVID-19 to receive the add-on payment. The facility must also have members who are discharging from a hospital to an NF, have pending test results for COVID-19, or have a positive COVID-19 diagnosis. The payment is $300 per day per affected Medicaid member.

Suspension of PA for Certain Patients. DHS worked with the MCOs to suspend the PA requirement for patients who are discharged from an inpatient stay to a post-acute provider. This change was effective November 17, 2020, for both of the MCOs and is a temporary change.

Grants for Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IDs), Psychiatric Medical Institutions for Children (PMICs), and NF Providers. DHS provided grants to Medicaid-enrolled community-based ICF/ID, PMICs, and NFs to help offset impacts of the pandemic. All facilities physically located and licensed in Iowa received a grant from DHS via an electronic funds transfer. Ten million dollars was distributed to ICF/IDs and PMICs and $14 million was distributed to NFs using CARES Act funding received by the state. Each facility was required to complete an online attestation to keep the grant. If the facility did not want the grant or did not complete the attestation, DHS recouped the funds.

C. COVID-19 Testing Activity

Ms. Mary Stewart, Bureau Chief, MCO Oversight and Supports Bureau, Iowa Medicaid Enterprise (IME), reviewed COVID-19 testing and claims activity during the pandemic. COVID-19 testing and treatment is a covered benefit for both MCO and FFS Medicaid members. Ms. Stewart reviewed the number of Medicaid members tested and those testing positive, the number of members who have died, and the number of COVID-19 inpatient stays.

D. Claims Activity

Ms. Stewart noted that since March 2020, the MCOs have reported a significant increase in telehealth services with telehealth service claims increasing from approximately 9,400 claims in March 2020, to approximately 157,524 claims during the first quarter of fiscal year 2020-2021, and to over 451,000 total claims from March 13 to December 11, 2020, totaling about $38.7 million. Homemaker services were added as a benefit and have averaged approximately 2,000 claims per month since March 2020, with a total to date of 19,057 claims. Home-delivered meals were added as a benefit and this benefit has averaged about 6,000 claims per month since March 2020, with a total to date of 60,262 claims.

E. Disenrollment Plan

Ms. Amela Alibasic, Bureau Chief, Medicaid Eligibility, Policy, and the Health Insurance Premium Payment (HIPP) Program, DHS presented information on the Medicaid disenrollment plan. Due to federal requirements in the federal Families First Coronavirus Response Act (FFCRA) regarding maintenance of effort (MOE), states are required to maintain eligibility for Medicaid members enrolled on or after March 18, 2020, through the last day of the month in which the PHE ends, unless the individual member requests a voluntary termination of eligibility or the individual ceases to be a resident of the state.

CMS recently updated its interpretation of FFCRA, effective November 2, 2020, to require states to maintain eligibility for members, but established three tiers of coverage which serve as a framework for identifying when a state may transition members between Medicaid eligibility categories. The three-tier framework requires states to move members between eligibility groups as long as the eligibility groups are within the same tier or the member is moving to a tier with more robust coverage.

Iowa has not been disenrolling any Medicaid members who have been enrolled in Medicaid as of March 18, 2020, and members will not be disenrolled prior to the end of the PHE. If the PHE is not extended, DHS expects members to experience movement between coverage groups according

to the CMS interpretation. DHS has been conducting ex parte renewals/passive renewals for the duration of the PHE, but renewal forms that would have been issued have been suspended for the duration of the PHE. DHS is in the process of resuming the issuance of renewal forms to Medicaid members and members will be allowed 45 to 60 days to complete the renewal of their coverage. A notice of action will be provided to each Medicaid household once the renewal has been completed. When the PHE ends, DHS will not be automatically disenrolling any member who became ineligible at any point in time during the PHE, but instead DHS will have to redetermine eligibility for all of these individuals. DHS has been flagging cases they believe have become ineligible, totaling about 20,000 cases. However, in each case, DHS will have to complete another eligibility determination. It will be very challenging for both members and the agency as DHS unwinds the flexibilities and resumes the standard eligibility process. DHS will need additional time to address the backlog of renewals, there will be a large workload volume, and DHS will have to unwind the processes correctly. Some members will have to provide additional information, some members will lose services they have been receiving, and some members will completely lose eligibility once the PHE is over. Again, adequate notice will be provided to all members, members who have remained enrolled as a result of the MOE requirement will undergo a redetermination, and following the redetermination, if a member is no longer eligible due to exceeding income limits, DHS will forward an auto referral to the federally facilitated marketplace for other coverage options.

DHS is participating in regular weekly all-state COVID-19 calls with CMS to address and discuss enrollment issues. CMS has also provided states with guidance through FAQ documents during the PHE and will be providing further guidance on the PHE roll-off so states can process backlogs accordingly.

F. Committee Discussion

NF Grant Opportunities. Representative Fry asked how many NFs have utilized the opportunity for the grants available, how many qualified COVID-19 facilities there are in the state, and how much has been paid out in the $3,000 grants in total.

Ms. Steenblock responded that for civil monetary penalties grants, DHS received nine applications for in-person grants from nine facilities totaling about $20,000. DHS received 202 applications for technology grants for 312 facilities totaling approximately $751,000. With respect to COVID-19 relief add-on rates, through December 11, 2020, there were 587 claims totaling $1.6 million. Ms. Steenblock was not able to provide the actual total number of facilities that would qualify for the rate add-on, but stated that most if not all NFs would qualify for the rate add-on. She will provide this information to the committee.

Continuing Flexibility. Senator Mathis asked how DHS will evaluate the flexibilities that DHS will keep going forward and if there is data being collected to demonstrate some of the outcomes of the flexibilities.

Ms. Steenblock responded that retaining the flexibilities depends, in part, on the federal authority under which the PHE flexibility is provided. Some of the flexibilities will end on the date the PHE ends, some at the end of the month in which the PHE ends, and some will end at the end of the quarter in which the PHE ends. HCBS flexibilities are on an annual basis. DHS is carefully aligning the flexibilities for which they will need transition time. Changes that will be made to the system will have to be reviewed to avoid unintended consequences. In terms of evaluating and analyzing, in stakeholder calls DHS has asked which flexibilities are important to continue and is working with the MCOs and reviewing the expenses attributed to services. One flexibility DHS is focusing on is telehealth, and maintaining this would require changes at the federal level. DHS is aware of some flexibilities the federal government would not allow to continue because the flexibilities would require federal law changes rather than just a decision by

CMS. DHS is focusing not on abrupt termination of the flexibilities, but on a transition to be able to have communication plans and notify members and providers as to what the processes will be.

Add-on Payment Requirements. Senator Ragan asked if there were any requirements for the $300/day add-on payment for NFs, such as providing benefits to frontline workers or other specific requirements for the funds received. Ms. Steenblock responded that she was not aware of any additional requirements, but that she would provide more detail to the committee.

Telehealth Data. Representative Fry asked if DHS is performing a quarter-by-quarter analysis of telehealth utilization, and if the committee could be provided information about what this usage is in relationship to the decrease in elective surgeries. Ms. Lovelady responded that DHS does have data on quarter-to-quarter telehealth utilization, but would have to follow up with the committee with reference to how this relates to decreases in elective surgeries.

III. FY 2021-2022 and FY 2022-2023 Medicaid Budget — Joe Havig, Bureau Chief for Budget and Planning, DHS

Brief Overview of Budget. Mr. Joe Havig, Bureau Chief for Budget and Planning, DHS, stated that he had met with the Department of Management and the Legislative Services Agency on Friday, December 18, 2020, to establish joint budget estimates for the Medicaid program for FY 2021-2022 and FY 2022-2023. At the meeting, the group developed two scenarios: one based on receiving enhanced federal medical assistance percentage (FMAP) matching funds through March 2021, and one based on receiving enhanced FMAP through June 2021.

The PHE has two key impacts on the Medicaid projection. One is the MOE requirement which results in increased enrollment and costs to the Medicaid program which will continue as long as the PHE is in effect. The second impact is the increased FMAP of 6.2 percent that will continue through the end of the quarter following the end of the PHE. Currently, the FMAP would continue through March 2021, but if the PHE is extended another quarter, the FMAP would continue through June 2021. The first presentation slide reflects the assumption that the FMAP continues through March 2021. Mr. Havig reviewed the two scenarios for the committee, including the projected ending balances. The budget passed by the general assembly for FY 2020-2021assumed only one quarter of enhanced FMAP. The first scenario presented builds in an additional two quarters of enhanced FMAP. For each quarter that the enhanced FMAP is in effect, the savings to the state general fund is roughly $70 million. While DHS is projecting increased enrollment and costs during the PHE, year-to-date activity has trended a bit below what was originally built in to the budget. In FY 2021-2022, the forecasting group is also projecting a large surplus, even without the increased FMAP. This is due to two key factors: first, under current law, the FY 2020-2021 ending balance will be available in FY 2021-2022 and does not revert; and second, for the Iowa Health Link program, the estimates are for lower spending in FY 2021-2022 compared with FY 2020-2021. The lower enrollment and spending are primarily due to the fact that with the end of the PHE, Medicaid eligibility reviews will be reinstated and those who are no longer eligible for Medicaid will be disenrolled. Accordingly, lower enrollment and spending is estimated for FY 2021-2022. Regarding the Iowa Health Link Program, there are a number of adjustments built into the FY 2020-2021 budget that will not be built into the FY 2021-2022 budget, the largest being the health insurer fee payment mandated by the federal Affordable Care Act that sunseted in FY 2020-2021 and was built into the budget at about $20 to $25 million.

The second presentation slide reflects the enhanced FMAP through an additional quarter. There are two key changes compared with the scenario in which the PHE ends earlier. The changes are in the Iowa Health Link Program line and in the enhanced FMAP savings line. In the second scenario, the estimators

expect Iowa Health Link Program expenditures to increase in both FY 2020-2021 and FY 2021-2022 as a result of the requirement during the PHE for continued MOE, the resulting higher Medicaid enrollment, and the extension of the prohibition against disenrollments into FY 2021-2022. However, the projected increases are more than offset by the enhanced FMAP savings.

The third presentation slide is a chart of the managed care per-member per-month assumptions that underlie the financials. The blue line is the enrollment associated with the current PHE. The gray line is associated with an extension of the PHE for an additional quarter. Once the PHE ends, the new baseline is a bit above the old baseline but far below the COVID-19 baseline.

Monetary Findings Associated with the Audit of the Health Home Program. Mr. Havig addressed the federal Office of Inspector General (OIG) audit of Iowa's Health Home Program (HHP). The OIG started an audit of the HHP in 2018. The OIG selected a review period of four years, reviewing HHP claims from 2013 through 2016. As a result of the claims documentation issues identified, there was a significant monetary finding associated with the audit of approximately $37 million. The state payments to the federal government will be made over an eight-quarter period, with approximately $19 million being paid in FY 2020-2021 and FY 2021-2022. These amounts are built into the current budgets presented.

Committee Discussion.

Beyond Enhanced FMAP. Representative Fry asked what a future looks like post-enhanced FMAP. Mr. Havig responded that in either scenario presented, even though the state would be realizing significantly less federal financial participation in the future, the state would still be in a projected surplus status due to the large balance carried forward from year to year and due to the expectation that expenditures will decline once disenrollments take place. However, in FY 2022-2023 and beyond, there will be funding needs in the Medicaid program again because the carryforward will have been spent and normal Medicaid trends will be back in place. Additionally, Mr. Havig noted that none of the numbers presented included any changes to the MCO capitation rates for the second part of FY 2020-2021 or for FY 2021-2022. Once these rates are finalized, they will impact the ending balances. Representative Fry cautioned that while it seems that there is a healthy balance on the Medicaid bottom line, the balance will eventually be eliminated and there are many factors that could reduce the ending balance very quickly.

Disenrollment. Representative Forbes asked how people can request voluntary disenrollment if they have other coverage available, and whether there has been a reduction in claims activity that MCOs would otherwise pay out to providers over the last nine months, such that the capitation rates will remain steady or even be reduced. Ms. Jean Slaybaugh, Chief Operating Officer, DHS, responded that there are a significant number of factors that affected the spending under the capitation rates during the pandemic. DHS held the capitation rates steady for the first six months of FY 2020-2021 in order to be able to look back to determine what affected the capitation rates one way or the other. There is a meeting later this week to discuss capitation rates and DHS continues to work through negotiations with the MCOs so additional information should be available soon.

IV. Managed Care Organization Updates on COVID-19 and Derecho Response

Mr. Jeffrey Jones, President, Amerigroup, and Mr. Mitch Wasden, President and CEO, Iowa Total Care (ITC), presented regarding the response of each of the MCOs to COVID-19 and the derecho.

Amerigroup. Mr. Jones reviewed the highlights of working with the IME as COVID-19 flexibilities were implemented. He noted that real-time data sharing was an important component and that new tools were developed to obtain a better understanding of local communities and existing disparities.

Communication was very important in managing alongside providers. Amerigroup helped with providing personal protective equipment (PPE) support and acted as an information source. Amerigroup was already an 80 percent work-at-home business, so the transition during the pandemic was a bit easier. Amerigroup had weekly meetings with associates which acted as a business meeting as well as a wellness check. Amerigroup addressed community needs relating to food insecurity, personal protective equipment, social drivers of health activities to benefit members and communities, and member education and communications. Amerigroup will also remain connected as the state moves forward with Medicaid changes, vaccination education and communication, and will apply lessons learned. Mr. Jones concluded with a member success story.

With regard to Amerigroup's response to the derecho, Mr. Jones noted that challenges included power outages, displaced members, and food insecurity. Amerigroup worked to determine the status of its members, and followed up with its most vulnerable members. Flexible policies were implemented to address the specific member situation. The identified emerging trends in member needs ranged from food, to housing, to electric power, to durable medical equipment and supplies, to transportation. The derecho also affected Amerigroup associates which resulted in assessing capacity and deploying available resources. Providers were also affected, but Amerigroup worked initially with hospitals in the affected area and then with other providers to redirect members and support providers. An Iowa-based community relations team performed clinic visits and door-to-door wellness checks. Amerigroup provided funding to five food banks in the storm zone, provided ongoing support to the American Red Cross, and funded assistance to federally qualified health centers serving the hardest hit communities. Amerigroup provided 50,000 shelf-stable meals at a mobile food pantry in one week. Mr. Jones ended with a member success story.

ITC. Mr. Wasden reviewed ITC's response to COVID-19 and the derecho. Mr. Wasden stated that everyone should be proud of the level of coordination and collaboration among all entities in helping fellow Iowans. Many of the needs were met through a cascading response once the needs were identified. ITC had command centers for both COVID-19 and the derecho to organize efforts. Within ITC, the efforts were organized around three layers. One is the provider relations layer. ITC divided the state into 13 regions for provider relations, a group of 25 individuals who communicate with providers to determine their needs. The next layer is the case manager layer. Even though ITC has 800 employees in Iowa, about 500 are dedicated to being case managers. Several hundred live in the communities served. Many times, case managers are linked to those with chronic illness, but during the derecho, there was a whole new group of people who became high risk and required case management resources. The third layer is member connection representatives. These are the staff that are also imbedded in the community to find the members who are hard to find, such as the homeless or those in shelters. Some flexibilities that significantly helped providers were the pharmacy edits, suspending prior authorization requirements, expanding telehealth which has exploded in a positive way, and the retainer payments for HCBS providers and add-on payments for nursing facilities. Going forward, as the vaccine is rolled out, ITC will have to coordinate members receiving the initial vaccine and the second dose. ITC will use the newest technologies including texting programs with members to engage them regarding the vaccine. Another issue during COVID-19 was providing meals to those who did not qualify for meals before COVID-19. Since COVID-19, ITC has provided an additional 250,000 meals to members who normally would not be eligible. Mr. Wasden provided slides detailing how ITC responded to COVID-19 and the derecho in the community. The provider associations were critical in these responses. There was also great communication with DHS and the Governor's office in responding quickly during the derecho. Mr. Wasden related member experiences.

Committee Discussion

Positive Aspect of Transition to MCOs. Representative Fry observed that the way that MCOs can respond in natural disasters and pandemics, in instances where there are large needs, was perhaps the most massive outreach effort since the shift to MCOs. This is one of the huge advantages of transitioning to MCOs.

Thanks. Senator Mathis thanked the MCOs for all of their work related to the derecho. The discussion with city leaders was an eye opener as to social determinants of health and how many Medicaid members are in the community. Local leaders and the public were shocked by how many people need food assistance and other assistance.

Senator Miller-Meeks and Senator Edler also echoed the thanks and appreciation to both MCOs and to DHS for their response during the pandemic and the derecho.

V. Public Comment

Ms. Shelly Chandler, Executive Director, Iowa Association of Community Providers, also echoed the thanks to the MCOs for their assistance during the pandemic and the derecho.

VI. Materials Filed with the Legislative Services Agency

Documents distributed at the meeting are posted on the committee's Internet site: www.legis.iowa.gov/committees/meetings/documents?committee=241656ga=ALL