Department of HUMAN SERVICES

Health Policy Oversight Committee

Iowa Medicaid's COVID-19 Response

December 21, 2020
AM Presentation

Overview

- Iowa Medicaid's Response to COVID-19
  - o Members
  - o Providers
- COVID-19 Testing Stats
- Claims Activity during COVID-19
- Disenrollment plan

Iowa Medicaid's Response to COVID-19

- Iowa Medicaid received approval from the Centers for Medicare and Medicaid Services (CMS) for several different waivers and State Plan Amendments (SPAs) to ensure continuous and expanded services for Medicaid members during this pandemic.
- There were also a number of flexibilities that we were able to implement because of blanket waivers and rules issued to all states by CMS.
- All of these are in place through at least the end of the federal public health emergency (PHE), which is currently scheduled to expire on January 22, 2021.

Member Response

No disenrollments

- Since March 2020, no one has been disenrolled or has had their services reduced due to an inability to pay a premium, complete Healthy Behaviors, or other means. This will continue throughout the federal COVID-19 public health emergency (PHE).

No premiums

- All co-pays, contributions and premiums have been waived through the duration of PHE.
- This applies to the Iowa Health and Wellness Plan (IHAWP), Hawki and Medicaid for Employed Persons with Disabilities (MEPD) programs.

Member Response

COVID-19 testing for uninsured

- Uninsured individuals who wish to be tested for COVID-19 can apply for COVID-19 Testing medical coverage on the DHS website.
- The health coverage an individual gets if they are approved is only to pay for medical tests for COVID-19, it does not help the individual pay for other medical costs.

Member Response

Expanded telehealth services

- Prior to COVID-19, Iowa Medicaid allowed telehealth for members if they were in certain originating sites: a hospital or a community health center.
- In March, Iowa Medicaid expanded telehealth services (both audio only and video) to allow all providers to utilize, from any location, when clinically appropriate, and necessary to preserve the health and safety of Medicaid members.
- Providers must practice within the scope of their practice and the telehealth services rendered must be documented.
- All telehealth services are currently paid at parity to face-to-face visits.
- Telehealth will be in place through at least the end of the federal PHE.

Member Response

Expanded home delivered meals, homemaker, and companion services

- Due to COVID-19, the Department expanded home delivered meals and homemaker services to all current members receiving Home- and Community-Based (HCBS) waiver or habilitation services and Medicaid members who are home bound due to COVID-19.
- For companion services this was only an alternative to replace habilitation, supported community living or Consumer Directed Attendant Care (CDAC) services that were unavailable, yet supports were needed.

Member Response

Extended PAs for elective procedures that were delayed/cancelled

- Prior authorizations (PAs) for Medicaid members were not waived during the pandemic, nor were PAs extended for continuity of care.
- What we did do, however, was extend PAs (in 30-day increments) that were approved by the MCOs, dental plans or the IME for Fee-for-Service (FFS), for elective procedures that were delayed or cancelled in March through May 2020, due to COVID-19.
  - Elective procedures: Hip, knee replacements.
- Department approved; did not need CMS approval.

Provider Response

Answering questions from providers

- Once we made the announcement about the extended services and flexibilities, we started receiving questions from providers.
- We made a dedicated effort to promptly answer these questions and post them on our website so that providers could get up-to-date guidance.
  - We created a new COVID-19 Frequently Asked Questions (FAQ) section on the DHS website and added new questions daily.
  - All of the questions and answers were also put into a provider toolkit that could be easily downloaded and shared with staff at provider offices.

Provider Response

Answering questions from providers

- We have a dedicated IMECOVID19@dhs.state.ia.us email address where providers can continue to send questions in.
- Back in March, as information was changing quickly, we held weekly calls with providers to talk about Medicaid updates related to COVID-19 and answer questions.
- As the weeks passed and the public health emergency got extended, the updates and questions started to dwindle.
- We shifted the frequency of the calls to every other week and then eventually to once a month.
- We want to continue to be open and transparent with providers about program changes so we're going to continue to hold regular stakeholder calls through the unwinding following the end of the PHE as well as post pandemic.

Provider Response

Extended timely filing for an extra 90 days

- 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.
- Prior to COVID-19, providers had 180 days to submit first time claims.
- FFS and dental timely filing is at 365 days and remains unchanged right now.
- After the pandemic we plan to return to normal billing guidelines.
- Department approved; did not need CMS approval.

Provider Response

Civil Money Penalties funding for nursing facilities

- Nursing facilities can apply for grants to purchase communicative technology devices for residents to use or funds for in-person visitation aids during the COVID-19 PHE.
- Grants are up to $3,000 per facility for technology devices and in-person visitation aids.
- Facilities are reimbursed after submitting receipts to the Department.
- Facilities can apply for both grants.
- The Department is accepting grants through the end of the PHE.

Provider Response

Retainer payments for HCBS and habilitation providers

- HCBS and Habilitation Providers were able to bill the MCOs for retainer payments for certain services there were unable to render during the month of April 2020.
- Retainer payments were allowed when a member was unable to receive normally authorized and scheduled services due to hospitalization, short term facility stay, or isolation, or due to closure of a provider's service line(s) for reasons related to the COVID-19 emergency.
- The retainer payments were based on an average month of service pre-COVID.

Provider Response

CARES Act relief grants for HCBS, MH and SUD providers

- The Department distributed $50 million in CARES Act grants to HCBS waiver and habilitation direct service providers, substance use disorder, and mental health service providers to help offset impacts of the COVID-19 pandemic.
- Of the $50 million, $30M went to HCBS, $10M went to mental health (MH), and $10M went to substance use disorder (SUD) providers.
- Eligible providers applied online for a grant.
- The Department issued payment to providers based on respective claims data from State Fiscal Year 2019 (SFY19).

Provider Response

Enhanced dental payment

- As part of the COVID-19 emergency declaration, the Department allowed a temporary enhanced payment to dental providers and orthodontists to help address facility and safety upgrades.
- This was 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, Hawki, and Medicaid FFS dental claims.

Provider Response

COVID-19 Relief Rate (CRR) Add-On Payment

- CRR payments are available to Medicaid certified skilled nursing facilities and nursing facilities during the PHE to provide financial assistance to facilities that incur unexpected costs when caring for Medicaid members who are diagnosed with or quarantined for potential COVID-19.
- The facility must have a designated isolation unit for the treatment of COVID-19; or the facility, in its entirety, is designated for the treatment of COVID-19.
- In addition, the facility must have enrollees who are discharging from a hospital to a nursing facility; or are pending test results for COVID-19; or have a positive COVID-19 diagnosis.
- The payment is $300 per day per Medicaid member who is COVID-19 positive.

Provider Response

Temporary suspension of PA requirement for inpatient discharges to post-acute providers

- An effort to provide support for healthcare system capacity during the surge in COVID-19 cases.
- Effective November 17, 2020 for both Managed Care Organizations (MCOs).
  - Change was immediate in claims systems so there wasn't any denials for not having a prior authorization on file.
- It's a temporary change.

Provider Response

Grants for ICF/ID, PMIC, and NF providers

- IME provided grants to Medicaid-enrolled Community-Based Intermediate Care Facilities for the Intellectually Disabled (ICF/ID), Psychiatric Mental Institutions for Children (PMICs), and Nursing Facilities (including Nursing Facilities for the Mentally Ill) to help offset impacts of the pandemic.
- All eligible facilities physically located and licensed in Iowa automatically received a grant from the Department via Electronic Funds Transfer (EFT).
- $10 million given to ICF/IDs and PMICs; $14 million to NFs.
  - CARES Act money the State received.
- The facility needed to complete an online attestation to keep the grant.
- If the facility didn't want the grant, or didn't complete the attestation, the Department recouped the money.

COVID-19 Testing

COVID-19 testing and treatment is a covered benefit for Medicaid members (MCO and FFS)

- Total individuals tested: 121,000 (through December 11, 2020)
- Total tested positive: 6,277 (through December 11, 2020)
- Total COVID-19 deaths: 400 (through December 11, 2020)
- Total COVID-19 inpatient stays: 8,786 (through December 11, 2020)

Claims Activity During COVID-19

COVID-19 started in SFY20, Quarter 3

- Since March 2020, the MCOs have reported a significant increase in telehealth services.
- There were 9,386 total telehealth service claims in March 2020.
- This number rose to 157,524 during the first quarter of SFY21 (July, August, and September 2020).
- From March 13 to December 11, 2020, there were 451,024 total telehealth claims and about $38.7 million paid out on these claims by the MCOs.
- Homemaker services were added as a benefit and have averaged about 2,000 claims a month since March 2020. (Total: 19,057 claims)
- Home delivered meals was added as a benefit and have averaged about 6,000 claims a month since March 2020. (Total: 60,262 claims)

Disenrollment Plan

- Maintenance of Effort (MOE) under the Families First Corona Virus Response Act (FFCRA) requires states to maintain eligibility for a member enrolled on or after March 18, 2020 through the last day of the month in which the PHE ends.
  - Exception: the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the state.

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

Disenrollment Plan

- Iowa has not been disenrolling any 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 does not get extended beyond January 22, 2021, it is expected that members will still experience movement between coverage groups, according to the CMS interpretation outlined in the published final rule.

- Iowa has been conducting ex-parte renewals/passive renewals for the duration of the PHE, but renewal forms that would have had to be issued, have been suspended for the duration of the PHE. The Department is in the process of resuming issuing renewal forms to members and members will be allowed 45-60 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.

Disenrollment Plan

- No member will be disenrolled from the Medicaid program based on previously verified information and instead all members who have remained enrolled as a result of the MOE requirement, will undergo another redetermination before determined whether Medicaid coverage can continue. If no longer eligible because exceeding income limit, the Department will send an auto referral to the Federally Facilitated Marketplace for other coverage options.

- The Department is participating in regular weekly all-state COVID-19 calls with CMS where the enrollment issues are continuously addressed and discussed in detail. CMS has also provided states with guidance through FAQ documents throughout the PHE period and will be providing further guidance on the PHE roll-off, so states can accordingly process the backlogs that will require attention once the PHE ends.