IOWA MEDICAID COVID-19
PROVIDER TOOLKIT

Updated April 2, 2020

Department of
HUMAN SERVICES

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MEDICAID FLEXIBILITIES REQUESTS

The Department has made the following requests to the Centers for Medicare and Medicaid Services (CMS) to continue serving Medicaid members during the COVID-19 emergency. The Department will implement requests as needed

CHIP/HAWKI AGE-OUT

- Continued eligibility for Children's Health Insurance Program (CHIP) enrollees who turn 19 years old during the national emergency and who are otherwise ineligible for Medicaid due to income above 133% of the federal poverty level (FPL).

CHIP/HAWKI ELIGIBILITY

- Extend eligibility to CHIP members beyond their certification period.
- Provide CHIP members additional time to submit renewal or verification materials.

CONTINUOUS ELIGIBILITY

- Establish up to 12-months of continuous eligibility for all Medicaid enrollees age 19 and over (already in place for those under age 19).

COST SHARING SUSPENDED

Suspend cost-sharing for all members and suspend premiums for:

- Medicaid for Employed People With Disabilities (MEPD)
- Iowa Health and Wellness Plan (IHAWP)
- Dental Wellness Plan (DWP)
- Healthy and Well Kids in Iowa (Hawki)
- Client participation is not suspended.

COVERAGE FOR UNINSURED

- Cover COVID-19 testing and related visits for uninsured individuals during the emergency, as allowed under the recently passed Families First Coronavirus Response Act.

HOME DELIVERED MEALS

- Provide home delivered meals, subject to prior authorization, for Medicaid enrollees who are not enrolled in a 1915(c) waiver and are homebound due to the national emergency.
- Provide home delivered meals for all 1915(c) enrollees who are homebound due to the national emergency.

HOSPITAL PRESUMPTIVE ELIGIBILITY

- Allow hospitals to conduct presumptive eligibility for all Medicaid eligibility groups until the national emergency declaration is lifted.

HOSPITAL 24-HOUR NURSING FLEXIBILITY

- Waive the 24-hour nursing requirement, which will permit a nurse to cover more than one ward in the event of staffing shortages caused by the national emergency.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) FLEXIBILITIES

- Waive the requirement for direct care residential living unit staff, which will allow changes to direct care staff numbers, if necessary, due to the national emergency.

(Continued)

- Waive the continuous active treatment program requirement, which will allow the health and safety needs of residents to be met if sufficient staff are unavailable to implement continuous active treatment due to the national emergency.
- Waive the preventive care and dental services requirement, which will allow for flexibility if the timeliness requirements cannot be met due to the national emergency.
- Waive the housing of similar ages, developmental levels and social needs requirement, which will allow for movement and housing based on availability of sufficient staffing and potential health issues of clients.

LONG TERM SERVICES AND SUPPORTS (LTSS)

- Extend minimum data set authorizations for nursing facility and skilled nursing facility residents

NON-EMERGENCY AMBULANCE SUPPLIERS

- Temporarily allow non-emergency ambulance suppliers.

PUBLIC NOTICE REQUIREMENTS

- Waive requirement to seek public comment prior to CMS submission.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

- Waive the PASRR, which will allow a nursing home to continue admission of an individual who has not had an assessment completed if there is a workforce disruption or hospitals reduce or limit outside contact in their facilities.

PROVIDER ENROLLMENT

- Waive payment of application fee to temporarily enroll a provider
- Waive site visits to temporarily enroll a provider
- Permit providers located out-of-state/territory to provide care to an emergency State's Medicaid enrollee and be reimbursed for that service
- Streamline provider enrollment requirements when enrolling providers
- Postpone deadlines for revalidation of providers who are located in the state or otherwise directly impacted by the emergency
- Waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state
- Waive conditions of participation or conditions for coverage for existing providers for facilities for providing services in alternative settings, including using an unlicensed facility, if the provider's licensed facility has been evacuated
- Temporarily delay or suspend onsite re-certification and revisit surveys, and enforcement actions, and allow additional time for facilities to submit plans of correction.

REPORTING AND OVERSIGHT

- Modify deadlines for OASIS and Minimum Data Set (MDS) assessments and transmission
- Suspend 2-week aide supervision requirement by a registered nurse for home health agencies
- Suspend supervision of hospice aides by a registered nurse every 14 days' requirement for hospice agencies

(Continued)

RESIDENCY

- Consider beneficiaries evacuated from the state temporarily absent and maintain enrollment in their home state (for home state where disaster occurred or public health emergency exists)

TELEHEALTH

- Allow telehealth for any Medicaid service for which it is appropriate, regardless of member location.

TRIBAL NOTICE REQUIREMENTS

- Waive requirement to consult with tribes prior to CMS submission; tribes will still be informed of submissions as soon as the State is able to do so.

ADDITIONAL SERVICES

- Home delivered meals (as noted above)
- Companion services
  - Includes the alternative for companion services to replace habilitation services, supported community living, and consumer directed attendant care services that are unavailable if there is a shortage of providers or providers are not able to deliver goal directed service due to the COVID-19 emergency.
- Homemaker services
- Allow self-direction of the 3 added services

ALLOW CASE MANAGEMENT COMPANIES TO PROVIDE DIRECT SERVICES IN ORDER TO ADDRESS POTENTIAL PERSONNEL CRISIS.

EXCEED SERVICE LIMITATIONS

- Remove the annual cost limit for respite services on the Intellectual Disabilities Waiver.

HOME- AND COMMUNITY-BASED SERVICES (HCBS) REGULATIONS

- Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

OUT-OF-STATE BACKGROUND CHECKS

- Temporarily waive out-of-state background checks for Consumer Directed Attendant Care (CDAC) providers. The State will continue to conduct Iowa background checks during the emergency.

PARENTS AND FAMILY MEMBERS

- Allow parents and family members to provide direct services.
  - Services allowed include: home based habilitation services, supported community living, consumer directed attendant care, and meals

PROCESSES

- Allow an extension for reassessments and reevaluations for up to one year past the due date.
- Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- Adjust prior approval/authorization elements approved in waiver.
- Adjust assessment requirements.
- Add an electronic method of signing off on required documents such as the person-centered service plan.

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RETAINER PAYMENTS

- Option for State to make retainer payments when a member is unable to receive normally authorized and scheduled services due to hospitalization, short term facility stay, isolation, or closure of a service line for any of the services listed below of no more than 30 days related to the COVID-19 emergency:
  - Adult Day Care
  - Consumer Directed Attendant Care
  - Day Habilitation
  - Prevocational Services
  - Supported Employment.

SETTINGS FOR HCBS EXPANDED, IF NECESSARY AND APPROPRIATE

- Allow services to be provided in ICF/ID or other facility settings
- Allow direct care provider's homes to be authorized settings – subject to IME approval through an exception to policy request after all other options have been exhausted
- Allow direct care providers to move into member's homes – subject to IME approval through an exception to policy request after all other options have been exhausted
- Lift the existing limitation on five person homes to no longer designate an upper limit; providers allowed to consolidate members into homes, with this allowance limited by the home's capacity.

TELEHEALTH FOR TYPICALLY FACE-TO-FACE PROCESSES

- Level of care and need based assessment evaluations and reevaluations
- Service plan reviews
- Interim service plan changes based on member's change in needs
- Quarterly face to face case manager contacts

PROVISION OF SERVICES IN ALTERNATIVE SETTINGS

- Allow for the provision of services in alternative settings when a licensed facility or standard medical setting is unavailable due to the COVID-19 emergency
- Subject to approval from the IME

BLANKET WAIVERS

ANNOUNCED BY CMS, APPLICABLE TO ALL STATES WITHOUT NEED TO SPECIFICALLY WAIVE

SKILLED NURSING FACILITY (SNF): provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

CRITICAL ACCESS HOSPITALS: CMS is waiving the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

HOUSING ACUTE CARE PATIENTS IN EXCLUDED DISTINCT PART UNITS: CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient.

DURABLE MEDICAL EQUIPMENT: Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.

CARE FOR EXCLUDED INPATIENT PSYCHIATRIC UNIT PATIENTS AND INPATIENT REHABILITATION UNIT PATIENTS IN THE ACUTE CARE UNIT OF A HOSPITAL: CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient psychiatric units and excluded distinct part inpatient rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part to an acute care bed and unit.

CMS is also waiving requirements to allow inpatient rehabilitation facilities (IRFs) to exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such.

SUPPORTING CARE FOR PATIENTS IN LONG-TERM CARE ACUTE HOSPITALS (LTCH)S: CMS is allowing a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

HOME HEALTH AGENCIES: Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission.

TELEHEALTH

CAN PROVIDERS PROVIDE TELEHEALTH SERVICE FROM THEIR HOME?

The IME, in collaboration with our Managed Care partners, is working to develop additional guidance for providers around the waivers requested by the State that will expand the application of technology to service delivery for our members during the duration of the COVID-19 emergency. The Department intends for providers to utilize technology to facilitate appropriate care reimbursable within the Medicaid program during this public health emergency. Part of this emergency provision will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate and necessary to preserve the health and safety of our Medicaid member. Providers must practice within the scope of their practice and are reminded that services must be documented in accordance with applicable documentation standards.

Regarding billing: The location of the provider becomes the distant site and defacto office. The provider performing the service (e.g. individual therapy, evaluation, etc.), may bill POS 02 and their regular CPT or HCPS codes along with modifier 95 as appropriate.

WHAT IS MEANT BY TELEPHONIC CONTACT – ONLY VIDEO?

Telephonic contact refers to contact relating to or happening by means of a telephone system. It does not mean video only. For the duration of the current emergency, services that typically require direct or face to face contact may be rendered via telehealth when clinically appropriate to the member's condition and needs and when provided within the clinician's scope of practice. Nothing in this statement otherwise effects a provider's responsibility to bill only for service performed and to comply with legal authority related to proper billing, claims submission, cost reporting or related conduct.

Information about HIPAA

or Copy this link: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

OIG Policy Statement

or Copy this link: https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

IS AN AUDIO-ONLY CALL PAID AT A LOWER RATE THAN A VIDEO CONFERENCE CALL?

There is no change in reimbursement rate, structure or methodology. Refer to Informational Letter 2115-MC-FFS-CVD for billing.

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WILL IOWA MEDICAID BE ALLOWING DENTAL PROVIDERS TO BILL VIA TELEDENTRISTRY IN EMERGENCY SITUATIONS WHERE PATIENTS CAN REACH A PROVIDER IF NECESSARY USING PHOTOGRAPHS OR VIDEOS?

Yes. Iowa Medicaid is opening codes for teledentistry in response to the COVID-19 pandemic to ensure our members access to necessary care.

ARE PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT) AND SPEECH THERAPY (ST) SERVICES COVERED AT THIS TIME FOR TELEHEALTH WITH BOTH THE IME AND THE MCOS?

The Department intends for providers to utilize technology to facilitate appropriate care reimbursable within the Medicaid program during this public health emergency. Part of this emergency provision will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate and necessary to preserve the health and safety of our Medicaid member. Providers must practice within the scope of their practice and are reminded that services must be documented in accordance with applicable documentation standards.

IF A PROVIDER IS ENROLLED WITH IOWA MEDICAID AND CREDENTIALED WITH AN MCO, BUT THEIR CLINIC IS IN OMAHA, NEB. AND THEY ARE PROVIDING TELEHEALTH SERVICES TO IOWA MEDICAID MEMBERS LOCATED IN IOWA, WOULD THAT BE COVERED?

Enrolled providers delivering Medicaid service to enrolled Iowa Medicaid members are covered.

CAN PROVIDERS DO TELEHEALTH AT A DIFFERENT LOCATION THAN THEY TYPICALLY PRACTICE AT DURING COVID-19?

Yes.

IS TELEHEALTH ALLOWED FOR MENTAL HEALTH THERAPY SESSIONS?

The Department has expanded the telehealth benefit for mental health therapy sessions when the service provided to Medicaid members is clinically appropriate and within the provider's scope of practice. Covered telehealth provider types (e.g., psychiatrist, clinical psychologist, nurse practitioner, CNS, CSW, LISW, LMFT, LMHC or CADC) may bill POS 02 with their regular BH codes.

HAS THE IME CONSIDERED OFFERING ADDITIONAL GUIDANCE TO PROVIDERS AROUND TELEHEALTH – BOTH HOW TO PROVIDE TELEHEALTH SERVICES AND HOW TO BILL FOR THEM?

Yes. The IME team in collaboration with the MCOs is working to develop additional guidance, including billing guidance, for providers.

ARE OUTPATIENT PT SERVICES INCLUDED?

Yes, when clinically appropriate, documented appropriately and within the provider's scope of practice.

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CAN CHILDREN'S MENTAL HEALTH WAIVER SERVICES AND HABILITATION STAFF UTILIZE TELEHEALTH?

Yes, the Department intends for providers to utilize technology to facilitate appropriate care reimbursable within the Medicaid program during this public health emergency. Part of this emergency provision will allow services that by definition are direct contact services and are typically rendered in person to be rendered via telehealth when clinically appropriate and necessary to preserve the health and safety of Medicaid members. Providers must practice within the scope of their practice and are reminded that services must be documented in accordance with applicable documentation standards.

WILL GROUP THERAPY VIA TELEHEALTH BE REIMBURSED?

The Department has expanded the telehealth benefit to include group therapy when the service provided to the Medicaid member is clinically appropriate and within the provider's scope of practice. Providers may bill POS 02 with modifier 95.

WHAT IS THE PROJECTED TIMELINE WHEN THE NEW TELEHEALTH CODES AND COST-SHARE POLICIES WILL BE UPDATED IN YOUR SYSTEM FOR CLAIMS PAYMENT?

Procedure codes U0001 and U0002 for lab testing are available and payable. Another new lab test, CPT 87635 will be added e,ffective March 13, 2020. A new ICD-10 diagnosis code U07.1 will be added, effective April 1, 2020. Amerigroup Iowa systems will be configured for payment by March 31, 2020. Iowa Total Care systems will be configured for payment by April 2, 2020. IME systems are configured for payment.

WHAT PLACE OF SERVICE SHOULD BE USED FOR DRIVE-THRU COVID-19 TESTING SITES AND HOW SHOULD IT BE BILLED?

Providers should bill POS 15 (Mobile Unit). Hospitals billing POS 15 can utilize a CMS 1500 to bill TOB 014x – hospital lab service for non-patients. This TOB is used for hospital labs, in which, the only service performed on the patient are labs.

CAN TELEHEALTH BE DONE VIA FACETIME OR SKYPE?

Refer to Informational Letter 2115-MC-FFS-CVD regarding virtual visits. HIPAA guidelines must be followed and use of social media platforms is prohibited.

WHAT CPT CODES WOULD A PROVIDER USE TO BILL A 45-MINUTE SESSION (CURRENTLY USE CPT CODE 90834) AND A DIAGNOSTIC EVALUATION (CPT 90791)?

Covered telehealth provider types may bill POS 02 and their regular BH codes along with modifier 95 as appropriate.

DOES THE PATIENT HAVE TO BE ESTABLISHED IN ORDER TO RECEIVE TELEPHONIC AND/OR TELEHEALTH SERVICES?

The "established patient" requirement is part of the telehealth rules that are currently suspended. However, providers must practice within the scope of their practice and are reminded that services must be documented in accordance with the standards in Iowa Code. Use POS 02 and bill traditional CPT and HCPS codes along with modifier 95 as appropriate.

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FOR THE ORIGINATING SITE ARE THERE ANY RECORDS OR DOCUMENTATION THAT IS RECOMMENDED TO BE KEPT IN THE MEMBER FILE TO BILL THE FACILITY FEE?

441 IAC 79.3(3) should be referenced regarding what documentation should be kept for auditing purposes.

WHAT HAPPENS IF THE ORIGINATING SITE DOESN'T FILE A CLAIM FOR THE FACILITY FEE? ARE THESE CROSS-REFERENCED WITH THE DISTANT SITE'S CLAIM? COULD THE PAID DISTANT SITE'S CLAIM BE RECOUPED IF THE ORIGINATING SITE DOESN'T SUBMIT A CLAIM FOR THE FACILITY FEE?

The provider performing the service (e.g., individual therapy, evaluation, etc.), may bill POS 02 and their regular CPT or HCPS codes. The distant claim will be reimbursed as these are treated like face-to-face visits.

FOR BEHAVIORAL HEALTH INTERVENTION SERVICES (BHIS), CAN WE PROVIDE AND BILL FOR TELEHEALTH SERVICES WITH CLIENTS THAT ARE NOT COMFORTABLE HAVING A PROVIDER IN THEIR HOME?

Covered telehealth provider types may bill POS 02 with the regular behavioral health codes along with modifier 95, as appropriate. As this telehealth is related to and covers the COVID-19 pandemic and BHIS is an intervention, it is recommended that there is significant documentation about the telehealth intervention, how BHIS was performed in the past and how the intervention matches the level of service provided in the past.

HOW DOES THE DEPARTMENT PLAN TO DIFFERENTIATE THE TELEHEALTH/ TELEPHONIC SERVICES BEING PERFORMED? HAS THERE BEEN THOUGHTS ABOUT INCLUDING OR ADDING MODIFIERS TO IDENTIFY THE DIFFERENT SERVICES – ESPECIALLY FOR HOME- AND COMMUNITY-BASED SERVICES (HCBS)?

Current payment methodologies and codes should be used for billing for services that are provided via telehealth or telephonic means, even for HCBS services. If the service is not a service that is traditionally a telehealth service and would normally be performed face-to-face, the service should be billed as it normally would with POS 02 that will identify the services were provided via telehealth or telephonically.

TELEPHONE VISIT CODES 99441-99443 ARE NEW SERVICES RELATED TO THE COVID-19 OUTBREAK AND ARE NOT A TRUE TELEHEALTH ENCOUNTER, HOW SHOULD RURAL HEALTH CLINICS (RHCS) BILL THESE CLAIMS?

RHCs were added to deliver telehealth services as a distant site as of March 13, 2020. RHC providers should bill the T1015 code with POS 02 to document the visit and bill any other CPT codes on the subsequent lines for informational purposes only. Payment will be made for the all-inclusive encounter rate.

HOW DO FACILITIES BILL FOR TELEHEALTH SERVICES WHEN THERE IS NO PLACE OF SERVICE ON A UB04? WOULD IT JUST BE THE MODIFIER?

Facilities should bill their regular codes (RV and CPT/HCPCS codes) and modifier 95, as appropriate, to denote services performed via telehealth.

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CAN A CRITICAL ACCESS HOSPITAL PROVIDE TELEHEALTH SERVICES AS THE DISTANT SITE PROVIDER IN AN RHC?

RHCs were added to deliver telehealth services as a distant site as of March 13, 2020. RHC providers should bill the T1015 code with POS 02 to document the visit and bill any other CPT codes on the subsequent lines for informational purposes only. Payment will be made for the all-inclusive encounter rate.

IS TELEHEALTH REIMBURSED IF THE 95 MODIFIER IS ADDED TO HOSPITAL-BASED CLAIMS, WHILE CHANGING THE POS TO 02 ON THE FREESTANDING CLINICS AND PROCEED WITH NORMAL CPT CODES?

Facilities should bill their regular codes (RV and CPT/HCPCS codes) and modifier 95, as appropriate, to denote services performed via telehealth. Professionals and freestanding clinics should bill POS 02 with modifier 95, as appropriate, and their regular service codes.

WHEN WILL THE VIRTUAL CARE SERVICES CODES BE ADDED TO THE FEE SCHEDULE?

The virtual care service codes are in the system and available for billing. The codes will be included in the next Medicaid Fee Schedule update.

ARE THESE CODES ONLY AVAILABLE DURING THIS PUBLIC HEALTH CRISIS OR WILL THESE REMAIN BILLABLE BEYOND THAT?

The expanded telehealth benefits are temporary and will be lifted post-pandemic.

FOR PROVIDERS DOING TELEHEALTH AT HOME DURING THE COVID-19 OUTBREAK, CAN THEY CONTINUE USING THE PRACTICE LOCATION IN BOX 32, WHICH IS LOCATION SERVICES RENDERED?

The location of the provider becomes the distant site and defacto office. The provider performing the service (e.g., individual therapy, evaluation, etc.), may bill POS 02 and their regular CPT or HCPS codes along with modifier 95, as appropriate.

IF NURSES ARE DOING A MEDICAL CHECK VIA TELEHEALTH, CAN THEY BILL THE Q3014? WHAT ABOUT THERAPY?

Covered telehealth provider types may bill POS 02 and their regular E/M codes along with modifier 95, as appropriate. Providers should not bill Q3014 for originating site fee when they are performing the actual service.

ARE HOME HEALTH AND HOSPICE COVERED UNDER TELEHEALTH? HOW DOES A PROVIDER BILL FOR THESE?

Hospice bills Iowa Medicaid on UB-04 using a revenue code that denotes the level of service, e.g., general inpatient, routine, respite, continuous care. The rate is an all-inclusive daily rate that would encompass services, drugs, DME, etc. that may or may not be provided via telehealth. The current billing process remains in effect. No changes are needed. For calculation of service intensity add-on (SIA) payments, visits may be performed via telehealth and the traditional code should be used with a modifier 95, as appropriate.

Home care bills Iowa Medicaid on UB-04 using a revenue code or the appropriate HCPCS code

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that denotes the service discipline visit, e.g., skilled nursing care, physical therapy, speech therapy, occupational therapy, medical social worker, home health aide. Payment for home care is based on LUPA and private duty nursing is based on an hourly fee. The current billing process remains in effect. Visits may be performed via telehealth and the traditional revenue code or HCPCS code should be used with a modifier 95, as appropriate.

ARE COMPLETE DIAGNOSTIC EVALUATIONS THROUGH TELEHEALTH COVERED?

The IME has expanded the telehealth benefit for diagnostic services when the service is provided to Medicaid members, is clinically appropriate and within the provider's scope of practice. Use POS 02 and bill traditional CPT and HCPS codes along with modifier 95, as appropriate.

DO PROVIDERS NEED TO USE BOTH POS 02 AND A MODIFIER 95 ON CLAIMS FOR TELEHEALTH SERVICES?

Use POS 02 and additionally use the 95 modifier, if necessary.

HOME DELIVERED MEALS

Expanded Home Delivered Meals Benefit Design

or Copy this link: https://dhs.iowa.gov/sites/default/files/Expanded%20Home%20Delivered%20Meals.pdf?032320201328

CAN ADDITIONAL MEALS BE PROVIDED EVEN IF NOT INCLUDED WITHIN THE CURRENT MANAGED CARE ORGANIZATION (MCO) MEAL PLAN?

Iowa Medicaid has requested authority to extend coverage of home-based meals to all waiver and home bound, non-waiver Medicaid members. However, the two meal per day limit remains in effect. For changes in individual member plans, connect with the member's MCO.

WHAT IS THE ROLE OF AREA AGENCIES ON AGING (AAA) IN HOME DELIVERED MEALS?

The expansion of the Medicaid benefit for home delivered meals does not change the role of the AAAs who currently provide home delivered meals to Medicaid members. All meal providers who identify a member who needs meal coverage as a result of the impact of COVID-19 should reach out to the member's Fee-for-Service (FFS) or Managed Care Organization (MCO) case manager. If the member does not have a case manager, connect to IME Member Services at 1-800-338-8366. The Iowa Department on Aging also plays a role regarding meals provided via resources outside of Medicaid.

HOW WILL MEAL PROVIDERS BE NOTIFIED THAT CLIENTS ARE APPROVED FOR HOME DELIVERED MEALS IF MEALS WERE NOT APPROVED UNDER THAT WAIVER INITIALLY?

Providers with questions about member-specific plan changes for waiver members should connect with the member's MCO community-based case manager or the FFS case manager.

HOW WILL MEAL PROVIDERS BE NOTIFIED OF INCREASED MEAL APPROVALS FOR THOSE THAT WERE ALREADY APPROVED AND RECEIVING HOME DELIVERED MEALS?

Providers with questions about member-specific plan changes for waiver members should connect with the member's MCO community-based case manager or the fee-for-service case manager. For home-bound, non-waiver MCO members, referrals may be made to an assigned community based case manager, the MCO member call center or other designated MCO point of contact as made available by the MCO. For home-bound, medically fragile, non-waiver FFS members connect to IME Member Services at 1-800-338-8366.

WILL THERE BE ANY DOCUMENTATION GIVEN THAT WILL ENSURE PROVIDERS WILL BE PAID FOR MEALS PROVIDED UNDER THIS APPROVAL?

The State has requested authority from the Centers for Medicare and Medicaid Services (CMS) to expand meal benefits during the duration of the emergency proclamation. For waiver members,

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connect with the MCO community-based case manager or FFS case manager to discuss individual plan changes. For home-bound, non-waiver MCO members, referrals may be made to an assigned community based case manager, the MCO member call center or other designated MCO point of contact as made available by the MCO. For home-bound, medically fragile, non-waiver FFS members connect to IME Member Services at 1-800-338-8366.

IF PROVIDERS ARE SET UP TO BILL WAIVER MEALS ARE THEY OK TO BILL ALL OTHER MEALS APPROVED AT THIS TIME?

Connect with the MCO or FFS case managers regarding any new or increased authorizations needed. If the member does not have an assigned case manager, connect to IME Member Services at 1-800-338-8366.

IS THE TIME SPAN FOR THIS APPROVAL THROUGH THE END OF THE CLIENT'S SERVICE PLAN DATE OR IS IT THROUGH A SET DATE ACROSS THE BOARD?

Approvals are anticipated to extend through the duration of the emergency proclamation.

WILL PROVIDERS RECEIVE AUTHORIZATIONS FROM EACH COMPANY DIRECTLY OR WILL APPROVALS BE REFERRALS FROM THE CASE WORKERS?

Providers should work with the MCO or FFS case managers directly.

CAN PROVIDERS OFFER ASSISTANCE WITH ONLINE ORDERING OF GROCERIES AND THEN HAVE STAFF PROVIDE PICK UP AND PORCH DELIVERY – WOULD THIS BE A BILLABLE SERVICE UNDER HOMEMAKER SERVICES?

Iowa Medicaid has expanded benefits for home delivered meals for members who are impacted by the COVID-19 pandemic.

PREMIUMS SUSPENDED

SHOULD PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) ORGANIZATIONS CONTINUE TO COLLECT CLIENT PARTICIPATION EFFECTIVE MARCH 2020?

Yes, there is no change to client participation.

DOES THE PREMIUM/SHARE OF COST SUSPENSION APPLY TO LONG-TERM CARE CLIENT PARTICIPATION COPAYS?

No. Client participation is not suspended at this time.

FOLLOWING THE SUSPENSION PERIOD, WILL A MEMBER WHO WAS PAST DUE ON THEIR HAWKI PREMIUM PAYMENT FOR JANUARY AND/OR FEBRUARY BE REQUIRED TO PAY THEIR PAST DUE BALANCE BEFORE RECEIVING SERVICES AGAIN?

Yes.

WILL SPENDDOWN FOR RESOURCE LIMIT OF $2,000 BE WAIVED DURING THE PANDEMIC?

We are not disenrolling anyone even if they've not spent down their resources. For any new applicant, they have to meet all eligibility requirements before they become eligible, including meeting the resource limit.

ARE INDIVIDUALS IN THE MEDICALLY NEEDY PROGRAM INCLUDED IN THE WAIVER OF COST-SHARING?

We are not disenrolling anyone, even if they've not spent down their resources. For any new applicant, they have to meet all eligibility requirements before they become eligible, including meeting the resource limit.

SOCIAL SECURITY INCOME (SSI)/UNEMPLOYMENT

DURING THE EMERGENCY DECLARATION WILL UNEMPLOYED INDIVIDUALS BE ALLOWED TO KEEP THEIR MEDICAID BENEFITS AND BE EXCLUDED FROM THE UNEARNED INCOME THAT THEY RECEIVE FROM UNEMPLOYMENT?

During this declared timeframe, loss of SSI benefits due to unemployment benefits will not dis-enroll an individual from Medicaid. However, when the declaration is lifted, if the member is no longer eligible for SSI, we would take appropriate action to re-determine eligibility under a different coverage group.

ARE ALL MEDICAID RECIPIENTS IN THE STATE REQUIRED TO NOTIFY DHS OF RECEIPT OF THE STIMULUS MONEY, AND IF NOT, WHO IS EXEMPT FROM THE NORMAL REQUIREMENT TO REPORT MONEY WITHIN 10 DAYS?

All Medicaid recipients are required to report the stimulus money.

HOW DOES THE STIMULUS PAYMENT AFFECT MEDICAID RECIPIENTS?

The Department continues to review analyses of the CARES Act and is awaiting guidance from CMS. It is the Department's assumption that the stimulus payments will not be counted as income for Medicaid recipients and applicants, however we are still awaiting guidance from CMS. It is also the Department's assumption that income not spent in the month of receipt will be excluded as an asset for up to 12 months. (This response is pending CMS guidance and is subject to change.)

IF THE STIMULUS PAYMENT IS NOT TREATED AS INCOME IN THE MONTH IT IS RECEIVED, THEN IT JUST BECOMES PART OF THE COUNTABLE ASSETS THE PERSON HAS. IN SOME CASES, AFTER A PERSON HAS RECEIVED AN ASSET, THE PERSON HAS SOME NUMBER OF DAYS TO GET BACK UNDER THE $2,000 LIMIT. HOW LONG IS THAT IN THIS CASE?

At this time, it is the Department's assumption that income not spent in the month it was received will be excluded as an asset for up to 12 months. (This response is pending CMS guidance and is subject to change.)

BEHAVIORAL HEALTH SERVICES

CAN BEHAVIORAL HEALTH INTERVENTION SERVICE (BHIS) BE PROVIDED USING TELEHEALTH?

All Iowa Medicaid covered services that our providers are able to provide via a telehealth mechanism, such as telephonic or video chat is included in the expansion of telehealth for the duration of this emergency. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider as part of the member's overall plan of support to determine appropriateness of delivery via telehealth.

CAN APPLIED BEHAVIORAL ANALYSIS (ABA) BE PROVIDED VIA TELECOMMUNICATION, TELEHEALTH, SMART PHONE VIDEO CONFERENCE OR OTHER ELECTRONIC MEANS?

The Department issued Informational Letter 2119-MC-FFS-CVD which provides guidance on services that typically require direct or face-to-face contact, may be rendered via telehealth when clinically appropriate to the member's condition and needs when provided within the clinician's practice. See general telehealth guidance above.

CAN SUBSTANCE USE DISORDER (SUD) SERVICES BE PROVIDED IN THE MEMBER'S HOME?

Yes, Opioid Treatment Programs (OTPs) providing buprenorphine treatment may render services in the member's home via telecommunication, telehealth, smart phone video conference or other electronic means. The Substance Abuse and Mental Health Services Administration has provided guidance to OTP providers.

HOME- AND COMMUNITY-BASED SERVICES (HCBS)

IS IT OK FOR A SUPPORTED COMMUNITY LIVING (SCL) PROVIDER TO GROCERY SHOP OR PICK UP MEDICATIONS FOR A MEMBER WHO WOULD NORMALLY PARTICIPATE IN THESE ACTIVITIES, BUT DUE TO COVID-19 IS UNABLE TO PARTICIPATE AT THIS TIME?

If a member is unable to leave their home due to a situation resulting from the COVID-19 pandemic, staff may complete tasks or activities that are identified in the member's service plan. Staff must engage the member in the activities to the greatest extent possible. If the service is billed as SCL in 15-minute units, the provider must engage the member using telephonic or video technology (e.g., Skype) so the member can be engaged in the SCL service delivery process. The billing must reflect the member's engagement and must only reflect the duration of the service delivered. Daily SCL providers bill in a daily unit for all services provided to the member during the day. Daily SCL providers will need to document all services provided and assure they meet the eight hours per day average criteria to bill the member's SCL daily rate.

CAN A PROVIDER CONTINUE A SERVICE THAT WOULD BE SUBJECT TO THE GOVERNOR'S PROCLAMATION?

The Governor's proclamation speaks to service settings and limits the number of persons able to gather. Those services should not continue at this time.

ARE SMALL GROUP EMPLOYMENTS SUSPENDED LIKE DAY HABILITATION AT THIS TIME?

Many employers and businesses are closed at this time. The Department considers small group supported employment services equivalent to other group settings that are suspended by the Governor's proclamation.

CAN A PARENT, LEGAL GUARDIAN OR IMMEDIATE FAMILY MEMBER PROVIDE HCBS SERVICES IF ANOTHER PROVIDER ISN'T AVAILABLE?

Yes. The State has requested this option in its waiver authority request for the duration of the COVID-19 emergency. Work with the member's case manager regarding provider needs and any changes that need to be made to member's service plans.

ARE WORKSHOP SETTINGS WITH MORE THAN 10 MEMBERS ALLOWED TO CONTINUE TO PROVIDE SERVICES?

Please follow the proclamation of the Governor. The Department cannot grant an exception to the Governor's proclamation.

WHAT SHOULD PROVIDERS DO REGARDING THE BILL THAT WILL MANDATE PAYING SICK LEAVE?

Providers are encouraged to monitor the Iowa Workforce Development website.

WHAT SHOULD BE DONE FOR SIGNATURES ON THE SERVICE PLAN AND THE CONSUMER-DIRECTED ATTENDANT CARE (CDAC) AGREEMENT WHEN THE INDIVIDUAL DEVELOPMENT TEAM (IDT) IS COMPLETED VIA WEBEX OR CONFERENCE CALL?

Work with the member's case manager. Both MCO and FFS case management have mitigation plans in place for signatures.

IF A PROVIDER WERE TO HAVE AN OUTBREAK OF COVID-19, AND THEY END UP HAVING MORE THAN FOUR INDIVIDUALS AT AN ISOLATION HOUSE AT THE SAME TIME, WOULD THAT BE OK?

Yes. This is part of the State's waiver authority request.

WHAT ADULT DAY SERVICES ARE INCLUDED IN THE GOVERNOR'S PROCLAMATION?

The Governor's proclamation speaks to service settings and limits the number of persons able to gather. This is impactful for all Iowans and includes, but is not limited to, day habilitation, prevocational services, and adult day care. Providers need to adhere to the proclamation. The Department cannot override the proclamation of the Governor.

ARE SUPPORTED EMPLOYMENT SERVICES SUSPENDED LIKE ADULT DAY CARE AND DAY HABILITATION AT THIS TIME?

Many employers and businesses may be closed at this time; however supported employment services may continue for members that are healthy, and who need support to maintain their jobs with employers who consider them essential workers.

ARE FACILITY BASED DAY SERVICE SETTINGS WITH MORE THAN 10 MEMBERS ALLOWED TO CONTINUE TO PROVIDE SERVICES?

The Governor's proclamation speaks to service settings and limits the number of persons able to gather together. This includes facility-based day habilitation, prevocational services, and adult day care.

ARE HCBS PROVIDERS CONSIDERED ESSENTIAL STAFF IF IT GETS TO THE POINT WHERE THERE IS A "SHELTER IN PLACE" ORDER?

Essential personnel guidance is issued by the Iowa Department of Public Health (IDPH). Please refer to "Isolation Guidance for Essential Services Personnel."

Isolation Guidance document

or Copy this link: https://idph.iowa.gov/Portals/1/userfiles/7/3222020UpdatedIsolation%20guidance%20for%20Iowa%20essential%20services%20personnel.pdf

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HOW SHOULD HCBS PROVIDERS, PARTICULARLY HOURLY/15-MINUTE SERVICES, MODIFY THEIR GOAL-BASED SERVICES SO THAT THEY CAN STILL PROVIDE AND BILL FOR SERVICES IF THEY CANNOT TAKE MEMBERS OUT IN THE COMMUNITY?

Providers will need to modify their service provision in a way to meet the individual's needs. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider in collaboration with the member and the IDT as part of the member's overall plan of support to determine appropriateness of delivery via alternate mechanisms, such as audio support or video conferencing.

CAN HCBS PROVIDERS TEMPORARILY WAIVE TRAINING REQUIREMENTS IF THEY HAVE EMERGENCY STAFFING NEEDS, AS LONG AS THE STAFF MEETS BACKGROUND CHECK REQUIREMENTS?

The Department is amenable to waiving training requirements in emergency staffing scenarios. For example, if a provider is unable to safely staff for member needs due to COVID-19 impact, the provider may choose to delay training required to meet some standards of accreditation. It is expected that providers will track any emergency planning deployed and will ensure staff complete their training once the emergency is mitigated.

CAN A PROVIDER DO DAY HABILITATION WITH ONE PERSON IN THE HOME AND HAVE THE OTHER PEOPLE DO THEIR NORMAL SUPPORTED COMMUNITY LIVING (SCL) ACTIVITY WITH THEIR SCL STAFF?

For the duration of the public health crisis the Department is waiving the requirement that day habilitation occur outside of the member's home. Providers will need to document the service delivery and ensure that the delivery and documentation aligns to what is billed. If audio will support the service delivery, it's acceptable. However, services that are more reliant on physical modeling, hands on intervention or visual observation will need to be vetted by the individual provider in collaboration with the member and the IDT as part of the member's overall plan of support to determine appropriateness of delivery via alternate mechanisms, such as audio support or video conferencing.

ARE PROVIDERS ABLE TO REQUEST AN EXCEPTION TO POLICY (ETP) TO ALLOW A "HOST HOME" SCENARIO FOR SCL AND HOME-BASED HABILITATION MEMBERS MOVING INTO STAFF HOMES UNTIL THE PANDEMIC IS OVER?

In reference to adult members, the Department does not plan to approve overarching ETPs for a provider to move all of their members served into "host home" like scenarios. Moving members from their homes into the homes of provider staff is expected to be used only a last resort option. If all other options are exhausted and the only path that preserves member safety is to move them out of their homes, providers need to work with the member's case manager and the IDT. All will need to agree to the change in the member's plan and safety planning will need to be in place. The agency remains responsible for ensuring the health, safety, and welfare of the members when services are provided in a staff home.

For Residential Based Supported Community Living (RBSCL) each individual request must receive Department approval.

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HOW WILL ASSESSMENTS FOR THE HCBS WAIVERS AND HABILITATION BE CONDUCTED DURING THE CURRENT SITUATION?

The Department will continue to process HCBS waiver applications, with some changes in processes to allow for applicant and assessor safety. interRAI has issued guidance about performing assessments through live video stream, including guidance for assessor awareness of effects on COVID-19 or isolation on the applicant/member. Supports Intensity Scale (SIS) off year assessments will continue to be done telephonically. Both IME FFS and the MCO assessment teams have plans in place to continue to conduct assessments safely.

WHAT SHOULD PROVIDERS DO IF THEY HAVE MEMBERS ASKING THEM TO TAKE THEM TO NON-ESSENTIAL PLACES AS PART OF THEIR HCBS SERVICES?

It is everyone's responsibility to do what we can to flatten the curve. Providers may need to limit their service provision to essential services only (such as support for medical appointments or grocery shopping) in response to the COVID-19 pandemic. Providers can use guidance provided by the Centers for Disease Control (CDC) when making decisions about limits they put in place on non-essential service delivery.

WITH PROVIDER OFFICES CLOSED CAN STAFF CALL IN, HAVE DOCUMENTATION TRANSCRIBED, AND GIVE A VERBAL SIGNATURE UNTIL THEY ARE ABLE TO COME IN AND SIGN? CAN PROVIDERS BILL WITH A VERBAL SIGNATURE?

Over the phone dictation, when necessary due to the impact of COVID-19, is acceptable with a documented verbal signature from staff. Staff must sign documentation as soon as possible. Providers are able to submit to billing with a verbal signature, however, providers are reminded that documentation may be subject to review later.

IF A MEMBER IS APPROVED FOR INTERIM MEDICAL MONITORING AND TREATMENT (IMMT) AND THEIR SISTER IS AN EMPLOYEE OF THE AGENCY, BUT IS 16 YEARS OLD, CAN THE AGE LIMIT BE WAIVED DURING THE PANDEMIC, AS THERE ARE NO OTHER AVAILABLE STAFF?

Work with the member's MCO Community-Based Case Manager (CBCM) or FFS Targeted Case Management (TCM) and the IDT to assess all options to support the member's needs. If all options are exhausted and there is a need to waive the age limit in order to maintain medically necessary services to the member, an ETP can be submitted via the typical ETP process.

FOR PROVIDERS OF HCBS SERVICES (INTELLECTUAL DISABILITY/ DEVELOPMENTAL DISABILITY) HOW ARE WE CLASSIFIED AS FAR AS ESSENTIAL VERSUS NON-ESSENTIAL? SHOULD WE ASSOCIATE AS AN INTERMEDIATE CARE FACILITY (ICF), RESIDENTIAL CARE FACILITY (RCF)?

HCBS provides community-based long-term care. Consider guidance related to essential personnel from the Iowa Department of Public Health. Providers are also encouraged to monitor the CDC website. DHS also has a broad range of COVID-19 resources.

CAN RESPITE BE PROVIDED WHILE FAMILY IS IN HOME OR WORKING FROM HOME?

Yes, this flexibility has been requested by the State for waiver services.

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HAS THE 30-DAY BED HOLD FOR INTERMEDIATE CARE FACILITIES (ICF) BEEN LIFTED?

If there is an individual need to waive the bed hold limit in order to maintain medically necessary services to the member, the provider should work with the member's MCO to submit an ETP via typical ETP process.

CAN RESPITE OCCUR WHILE THE PRIMARY CARETAKER IS WORKING FROM HOME DURING THE COVID-19 PANDEMIC SHOULD THE FAMILY NEED IT?

Yes, this flexibility is available, if appropriate to the member needs. Work with the member's case manager and IDT to make any necessary changes to the member's plan.

IS THE LONG TERM CARE HEALTHCARE SCREENING PROTOCOLS BEFORE WORKING (E.G. TAKING TEMPERATURE) GUIDELINES APPLY TO HOME CARE AGENCIES?

HCBS and home care are community-based long term care services. Everyone should be taking the necessary precautions as outlined by the IDPH.

HAS THE DEPARTMENT THOUGHT ABOUT REQUESTING THAT NORMAL MEDICAID RESPITE RESTRICTIONS BE TEMPORARILY LIFTED IF THE PRIMARY CARE GIVER IS ALSO DEEMED AN ESSENTIAL WORKER?

The additional flexibility allowed in the waivers from CMS is to allow caregivers working from home to access respite care for members. Additionally, member-specific flexibility can be granted, if needed, via an Exception to Policy.

WILL THERE BE AN EXTENSION OF MORE THAN 366 DAYS FOR THE INDIVIDUAL SERVICE PLAN (ISP) MEETING SINCE THERE CANNOT BE MORE THAN 10 PEOPLE IN A GROUP?

Case managers are working with members and their respective Interdisciplinary Teams (IDTs) to schedule ISP meetings via teleconference whenever possible. If the meeting is not able to be held, there are provisions to extend plans.

DO PROVIDERS HAVE TO COMPLETE ADDENDUMS TO PERSON CENTERED PLANS TO PROVIDE SERVICE VIA TELEPHONE?

If the service is in the plan and can be completed without "hands on" intervention, it can be done via telephone without needing a change to the person centered plan.

WILL SCHOOL AGED CHILDREN WHO RECEIVE RESPITE CARE HAVE ANY CHANGES PERMITTED TO THEIR CONTRACTS DUE TO SCHOOL CLOSURES?

Providers and IDTs can work with case managers regarding any needed changes in the member's service plan.

WILL RESPITE CARE SERVICE HOURS BE INCREASED?

Providers and IDTs can work with case managers regarding any needed changes in member service plans.

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ARE PARENTS ABLE TO USE RESPITE CARE WORKERS TO PROVIDE CARE FOR PARENTS IF THEY ARE WORKING?

The additional flexibility allowed in the waivers from CMS is to allow caregivers working from home to access respite care for members. Additionally, member-specific flexibility can be granted, if needed, via an Exception to Policy.

CAN DAY HABILITATION AND OTHER ADULT DAY PROGRAMS THAT HAVE LESS THAN 10 PEOPLE CONTINUE TO PROVIDE SERVICES?

Please follow the proclamation of the Governor. The Department cannot grant an exception to the Governor's proclamation.

IS THE DEPARTMENT PUTTING OFF LEVEL OF CARE REVIEWS FOR INDIVIDUALS ON THE HCBS WAIVERS?

Level of care assessors are completing reviews via alternate mechanisms whenever possible. If a review is not able to be completed, there are provisions to extend level of care review dates.

CONSUMER CHOICES OPTION (CCO)

IS THE DEPARTMENT GOING TO CONSIDER PAYING CCO EMPLOYEES EVEN IF THEY CAN'T CURRENTLY WORK FOR THE MEMBER SO THAT THE MEMBER DOESN'T LOSE THEIR EMPLOYEES DURING THIS TIME?

Our first priority is ensuring our members are supported. Anyone concerned about securing their income due to the impact of COVID-19 should connect with Iowa Workforce Development.

WILL PARENTS OR GUARDIANS HAVE TO COMPLETE BACKGROUND CHECKS OR GO THROUGH THE NORMAL PROCESS TO BECOME AN EMPLOYEE? ADDITIONALLY, WILL THEY STILL BE ABLE TO SIGN TIMESHEETS/BUDGETS, ETC. EVEN THOUGH THEY WOULD BE A PAID EMPLOYEE?

There is no change to the background check process.

CAN PARENTS OR GUARDIANS BE PAID PROVIDERS THROUGH CCO?

Yes. The State has been approved for this option in its waiver authority request for the duration of the COVID-19 emergency. A parent, guardian, or immediate family member can provide direct services to minor children. All CCO employees must submit an employment packet and pass the required background checks prior to payment.

IF THE PARENT OR GUARDIAN IS APPLYING TO WORK FOR THE MEMBER, CAN THE PARENT/GUARDIAN SIGN AS BOTH THE EMPLOYEE AND THE EMPLOYER ON TAX FORMS AND TIME CARDS?

Yes, for the duration of the COVID-19 emergency.

CAN A BUDGET BE CHANGED MID-MONTH?

The monthly budget amount cannot change during the month. Budgets can be changed during the month to reallocate how funds are used during the month. For example, adding employees or increasing or decreasing staff time due to sickness or inability to work shifts due to COVID-19. Any mid-month budget change must include all services that have been provided and billed prior to the change.

IF A MEMBER HAS TO LAY OFF AN EMPLOYEE, WOULD THEY BE ELIGIBLE FOR UNEMPLOYMENT?

Information on unemployment and COVID-19 can be found on the Iowa Workforce Development website.

CAN CCO FUNDS BE USED TO RETAIN STAFF?

No. CCO funds must be used to pay for direct service provisions.

CAN HOME DELIVERED MEALS, COMPANION AND HOMEMAKER SERVICES BE INCLUDED IN A CCO BUDGET?

The Department has been approved for these service options in its waiver authority request for the duration of the COVID-19 emergency. Work with the member's case manager regarding provider needs and any changes that need to be made to the member's service plans.

HEALTH HOMES

INTEGRATED HEALTH HOME (IHH) ELIGIBILITY: INDIVIDUALS ON MEDICAID FOR EMPLOYED PEOPLE WITH DISABILITIES (MEPD) WHO ARE NOT ABLE TO WORK RIGHT NOW ARE CONCERNED ABOUT LOSING MEDICAID DURING THIS TIME. IS THERE ANY OPTION TO WAIVE THIS EXPECTATION DURING THESE CIRCUMSTANCES?

Iowa has requested a waiver with CMS that will include an extension of eligibility and will waiver co-pays and premiums for MEPD during the COVID-19 pandemic.

IHH ENROLLMENT: WHAT IS THE BEST PRACTICE TO GET NEEDED PAPERWORK SIGNED UNTIL STAFF ARE ABLE TO MEET WITH FAMILIES FACE-TO-FACE?

The Department is requesting that if staff is not able to sign their name, they may type it on the form and put 'COVID' behind it. There is no need to have a face-to-face meeting with the member during the pandemic. Providers need to obtain release of information (ROIs) to request supporting documentation – which can take some time or providers, can request the guardian to contact the office and request a copy of what is needed. For signatures from members, write or type the name on the signature page and state completed by phone. Then once the quarantine is lifted, providers can go out and obtain signatures.

IHH ENROLLMENT: ARE PROVIDERS ABLE TO ENROLL MEMBERS BASED ON SELF-REPORT OR OUTDATED RECORDS?

No.

IHH ENROLLMENT: CAN PROVIDERS COMPLETE IHH ENROLLMENTS BY PHONE DURING THIS TIME?

Yes.

IHH SERVICES: DOES A MEMBER NEED TO BE SHOWING SYMPTOMS OF COVID-19 FOR A CARE COORDINATOR TO REPLACE A FACE-TO-FACE VISIT WITH A PHONE CALL?

Face-to-face visits have been suspended at this time to help control the spread of COVID-19 in Iowa. When clinically appropriate to the service being rendered, providers have the ability to render services that are typically face-to-face via telehealth, video conferencing or other electronic means. Further information regarding telehealth services is available in the "telehealth" section.

IHH SERVICES: WHAT CAN MEMBERS EXPECT WHEN IDENTIFIED AS NEEDING HOME DELIVERED MEALS ASSISTANCE?

Iowa has expanded Medicaid benefits to provide meals to Medicaid members who are home bound and concerned for access to meals due to the COVID-19 pandemic. Further information regarding home delivered meals is available in the "home delivered meals" section.

IHH SERVICES: HAS THERE BEEN ANY DISCUSSION ABOUT INCREASING INDIVIDUAL RESPITE FOR THE CHILDREN'S MENTAL HEALTH WAIVER?

Yes, providers may increase respite based on the needs of the member and they will be evaluated on a case-by-case basis.

IHH SERVICES: WILL PROVIDERS BE ALLOWED TO GO OVER THEIR MONTHLY LIMIT FOR INDIVIDUAL RESPITE?

This would require a plan change. Follow the normal process for this.

IHH SERVICES: IS THE INTERDISCIPLINARY TEAM ABLE TO REQUEST AN INCREASE OF HOME-BASED HABILITATION UNITS AND/OR TIERS TO SUPPORT MEMBER NEEDS?

Yes, the interdisciplinary team is able to request an increase in home-based habilitation units and/or tiers to support member needs.

IHH SERVICES: IS THERE ANYTHING IN STATE POLICY THAT WOULD REQUIRE A FACILITY TO MAINTAIN SERVICES WITH MEMBERS FOR A CERTAIN LENGTH OF TIME IN THE EVENT OF A STATE EMERGENCY?

The member's need for supervision and ability to self-supervise or to be alone for a period of time must be considered on an individual basis by the member and their interdisciplinary team and documented in the member's service plan as required by HCBS rules and regulations. The member's service authorization level must also reflect the amount of staff supervision and support needed. If the residential care facility were to close, they must provide advance notice and will be required to participate in a facility closure process with the Department and the Department of Inspection and Appeals, which includes frequent updates on their progress of finding alternative placements.

IHH SERVICES: CLOSURE OF PROGRAMS ARE AFFECTING HABILITATION SERVICES SUCH AS ENCLAVE AND DAY HABILITATION. HOW SHOULD PROVIDERS REPORT THIS IN REGARDS TO SERVICE TRACKING AND USE OF APPROVED UNITS?

Providers should document change in the member record and notify the IME and the MCOs.

IHH ASSESSMENTS: CAN PROVIDERS WAIVE THE REQUIREMENT FOR DISTRIBUTION OF THE INTERRAI WITHIN THREE DAYS?

Yes.

IHH ASSESSMENTS: CAN PROVIDERS COMPLETE THE QUARTERLY FACE-TO-FACE AND/OR CARE PLAN TEAM MEETING BY PHONE, IF NEEDED, DUE TO THE CIRCUMSTANCES SURROUNDING COVID-19? ARE PROVIDERS ABLE TO COMPLETE THE INTERRAI BY PHONE IF NEEDED?

Yes, when clinically appropriate to the service being rendered, providers have the ability to render services that are typically face-to-face via telehealth, video conferencing or other electronic means.

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IHH PERSON-CENTERED PLANS: CAN PROVIDERS WAIVE THE REQUIREMENT FOR DISTRIBUTION OF THE CARE PLANS WITHIN THREE DAYS?

There is no timeframe for the care plan.

IHH PERSON-CENTERED PLANS: IF A PROVIDER WANTS TO CHANGE THE FREQUENCY OF HOME-BASED HABILITATION OR THE TIER DIRECTLY RELATED TO THE CIRCUMSTANCES SURROUNDING COVID-19, DO THEY NEED TO UPDATE THE PERSON-CENTERED CARE PLAN / COMPLETE AND ADDENDUM?

Yes.

IHH PERSON-CENTERED PLANS: IS THE DEPARTMENT GOING TO UPDATE THE RIGHT RESTRICTIONS SECTION TO ADDRESS A RESTRICTION ON COMMUNITY TIME DUE TO THE CIRCUMSTANCES SURROUNDING COVID-19?

If the provider is not imposing more strict protocols than the Centers for Disease Control (CDC) recommends at this time regarding infection control or precautions with COVID-19, the right restrictions do not need to be updated.

IHH PERSON-CENTERED PLANS: IS IT NECESSARY FOR PROVIDERS TO ASK FOR ADDENDUMS IN ORDER TO CHANGE GOALS?

Assess the need to do an addendum based on the goal and how it is written.

IHH FACE-TO-FACE REQUIREMENTS: CAN A PROVIDER BILL THE INTENSIVE CARE MANAGEMENT (ICM) RATE FOR ALL ICM MEMBERS IF THEY HAVE DOCUMENTED ATTEMPTS TO CONTACT AND ARE WORKING WITH OTHER PROVIDERS TO SUPPORT THE SERVICE PROVISION?

Yes. Be sure to document all attempts.

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PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

CAN A PMIC ALLOW MORE THAN 30 RESERVED BEDS PER DAY FOR CALENDAR YEAR OR ALLOW MEMBERS TO BE GONE FOR MORE THAN 14 CONSECUTIVE DAYS IN A ROW?

The IME remains focused on ensuring children have all of the supports and services they need throughout the duration of the emergency. If a scenario comes up that a PMIC provider will need to exceed the current reserved bed days for a member due to the impact of COVID-19, they can file an exception to policy (ETP) to request the reserve bed day limit be waived.

LONG TERM CARE

WHAT IS THE EFFECTIVE START DATE OF WHEN THE IME IS SUSPENDING PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) FOR NURSING FACILITIES?

There is no effective date at this time. The IME will continue to evaluate and share information as it develops.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

WITH HOSPITAL MANDATES IN PLACE REGARDING VISITORS, CAN A MEMBER'S SPOUSE CONTINUE TO RECEIVE HOTEL AND MEAL REIMBURSEMENT THROUGH ACCESS2CARE WHILE THE MEMBER IS HOSPITALIZED?

There's been no change to policy relative to reimbursement available for spouses while a member is hospitalized.

OPERATIONS

WILL MEDICAID COVER THE COST OF N95 MASKS FOR PROVIDERS IF/WHEN ONE OF THE MEMBERS IN THEIR CARE HAS COVID-19?

If you have concerns about personal protective equipment, contact your local emergency management team.

Contact Emergency Management

or Copy this link: https://www.homelandsecurity.iowa.gov/documents/county/COORD_Public_List.pdf

WILL THE DEPARTMENT BE WAIVING THE ENFORCEMENT OF EMTALA TO TREAT PATIENTS OFFSITE TO PREVENT THE SPREAD OF COVID AND WAIVING CREDENTIALING REQUIREMENTS DUE TO THE PUBLIC HEALTH EMERGENCY?

Iowa Medicaid doesn't control the enforcement of EMTALA as it applies to all regardless of payer source. CMS issued guidance on March 9, 2020 regarding EMTALA. We will work with our MCO partners to discuss mechanisms to waive certain credentialing requirements in response to the COVID-19 pandemic.

HAS THE IME CONSIDERED SEEKING A WAIVER OF PRIOR AUTHORIZATIONS (PAS) FOR ALL MEDICAID MEMBERS DURING THE NATIONAL PUBLIC HEALTH EMERGENCY?

We are not seeking a waiver of all Medicaid PAs at this time. The IME is monitoring PAs, including time frames for approval, and will use this data to make any changes needed.

HAS THE IME CONSIDERED REQUIRING MCO INTERIM OR PERIODIC INTERIM PAYMENTS FOR PROVIDERS EXPERIENCING CASH FLOW ISSUES DUE TO THE GOVERNOR'S MANDATE TO CEASE NON-ELECTIVE SURGERIES AND OTHER PROCEDURES?

Providers impacted by the COVID-19 pandemic are encouraged to work with the MCOs regarding potential opportunities for relief. Any relief offered via the MCOs is likely to be offset by future claims and may be subject to cost settlement. In addition, the IME continues to explore options to support and maintain our provider network through the duration of the crisis.

HAS THE IME CONSIDERED SUSPENDING TIMELY FILING RULES FOR MEDICAID CLAIMS?

Pursuant to the Governor's state of emergency, Iowa Total Care and Amerigroup have extended initial filing for first-time claims submissions for both IA Health Link and Hawki as an interim policy change in response to the unprecedented demands related to Coronavirus and COVID-19. Effective with dates of service (DOS) beginning April 1, 2020, providers will have an additional 90 calendars days to submit first time claims and encounters. Specifically, providers must submit first time claims/encounters within

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270 calendar days of the date of service except as provided for in the Iowa Total Care and Amerigroup Provider Billing Manuals inclusive of retroactive eligibility claims & when Iowa Total Care and Amerigroup is the secondary payer. After the interim period ends Iowa Total Care and Amerigroup will return to normal billing guidelines. Providers are encouraged to reach out to their individual Provider Relations representative with any questions are concerns.

IS THE TEMPORARILY SUSPENSION OF TWO-WEEK AIDE SUPERVISION REQUIREMENTS BY A REGISTERED NURSE FOR HOME HEALTH AGENCIES INCLUDED IN THE 1135 WAIVER?

Yes, it was included in Iowa's 1135 request to CMS. IME is working with CMS to identify if it has the authority to implement.

HAS THE IME REQUESTED TO HAVE PRIOR AUTHORIZATIONS (PAS) CONTINUED BY THE MCOS DURING THE COVID-19 PANDEMIC?

We are not seeking a waiver of all Medicaid PAs at this time. The IME is monitoring PAs, including time frames for approval, and will use this data to make any changes needed.

WILL THE IME WAIVE THE REQUIRED 60 RECERTIFICATION FOR HOME HEALTH DUE TO COVID-19 CONCERNS?

Providers are encouraged to leverage telehealth mechanisms to complete recertification reviews.

DOES IOWA'S 1135 WAIVER REQUEST INCLUDE TEMPORARY SUSPENSION OF PA REQUIREMENTS FOR ALL LABORATORY TESTING OR JUST COVID-19 RELATED TESTS?

We are not seeking a waiver of all Medicaid PAs at this time. The IME is monitoring PAs, including time frames for approval, and will use this data to make any changes needed.

HAS THE DEPARTMENT ASKED CMS FOR PERMISSION TO SHORTEN THE REVIEW PROCESS BY THE MCOS FOR WHEN AN INDIVIDUAL FILES AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION?

We are not seeking a waiver of appeals time frames at this time. The IME is working closely with the MCOs to monitor time frames and will use this data to make any changes needed.

WILL COVID-19 TESTING AND TREATMENT COUNT FOR EMERGENCY MEDICAID FOR INDIVIDUALS WHO QUALIFY FOR EMERGENCY MEDICAID?

For individuals that qualify for medical assistance under emergency Medicaid which is known as Limited Medicaid for Certain Aliens, appropriate Medicaid services, including COVID-19 testing and treatment, would be a covered, emergent service. Providers should refer to Informational Letters 1546 and 1892 for more details about eligibility and coverage requirements under this provision.

HAS THE DEPARTMENT ASKED CMS FOR ANY SUPPORT FOR RURAL HOSPITALS?

Yes. Effective March 13, 2020, telehealth coding to identify Rural Health Clinics (RHCs) as originating sites has been opened. In addition, the overall expansion of telehealth supports all Iowa providers in ensuring

member access to care. Expansion of presumptive eligibility allows hospitals to conduct presumptive eligibility for all Medicaid eligibility groups until the national emergency declaration is lifted. Additionally, IME requested hospital 24-hour nursing flexibility which allows a nurse to cover more than one ward in the event of a staffing emergency. There are provisions contained in CMS' "blanket waivers" including provisions that lift the current 25-bed limit for critical access hospitals and also lift the 96 hour limit on length of stay. IME continues to work closely with CMS to identify developing opportunities in Federal legislation, including the provisions in the CARES Act. We will continue to share information as available.

WHAT IS THE DEPARTMENT'S PLAN AND PROCESS FOR MAKING RETAINER PAYMENTS THAT WERE PART OF THE DEPARTMENT'S APPENDIX K APPLICATION TO CMS?

The IME is working with CMS to determine if or how retainer payments can be deployed.

WHERE SHOULD EMPLOYEES GO TO RECEIVE A BADGE OR LETTING STATING THEY ARE AN ESSENTIAL EMPLOYEE?

There are no badges issued by the Medicaid agency identifying essential employees. Employers should monitor guidance from all sources, including Iowa Workforce Development and the Iowa Department of Public Health.

BILLING / REIMBURSEMENT

WHAT IS THE STATUS OF THE INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)?

The State has received the funds for the first quarter increase.

WHAT IS IME'S PLAN FOR THE INCREASED FMAP?

The IME is developing recommendations for utilization of the increased FMAP dollars. These recommendations will be based on estimates to include increased Medicaid beneficiaries and increased services available during the pandemic.

MCO RESOURCES

Amerigroup Iowa Coronavirus Information

or Copy this link: https://www.amerigroup.com/amerigroup/coronavirus.html

Iowa Total Care Provider Coronavirus Guide

or Copy this link: https://www.iowatotalcare.com/providers/coronavirus.html