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Iowa Health and Wellness Plan Interim Report
Coverage during the PHE

Elizabeth T Momany, PhD
Senior Research Scientist

Alex Sukalski
Director of IT Services

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Introduction

Iowa Medicaid was expanded on January 1, 2014, under an 1115 waiver to include adults ages 19-64 with 0-133% FPL who were not categorically eligible. The University of Iowa Public Policy Center has provided numerous reports detailing the results of the first demonstration period (January 2014-December 2019). These reports are available on the PPC website at Iowa Medicaid Expansion | Public Policy Center (uiowa.edu). The waiver was renewed on January 1, 2020. This report provides a brief look into Medicaid enrollment before and after the Public Health Emergency (PHE) that arose due to the COVID-19 pandemic. The report is the result of work being completed to determine the effects of the pandemic and federal PHE flexibility on Medicaid coverage as a basis for later adjustments to evaluation data collection, methods and analysis.

Iowa Medicaid PHE responses are summarized at 1207696.pdf (iowa.gov). A copy of the linked document is included for reference in Appendix A.

The most significant PHE-related Medicaid program changes for IHAWP evaluation are listed below.

- The Families First Coronavirus Response Act included a 6.2% percentage increase in the state's federal share for maintenance of eligibility (MOE), providing continuous eligibility for members enrolled as of March 18, 2020 through the end of the last month of the federal PHE. The federal share increase does not apply to adults in IHAWP as the federal share for group remains at the enhanced rate of 90%.
- All cost sharing was waived.
    - Waiver of premiums even if the Wellness visit and HRA are not completed
    - Waiver of the $8 copayment for non-emergent emergency room use.
- Dental Wellness Plan (DWP) members were no longer required to 1) complete the Healthy Dental Behaviors (every 6 month check-up and annual Caries Risk Assessment) or 2) pay a premium to maintain full dental benefits. DWP members on reduced benefits were provided full benefits. The DWP Healthy Behaviors program will be terminated at the end of the federal PHE.
- Telehealth requirements were expanded allowing visits to occur in the home without specialized personnel present through video or audio link.

Coverage

PHE flexibility

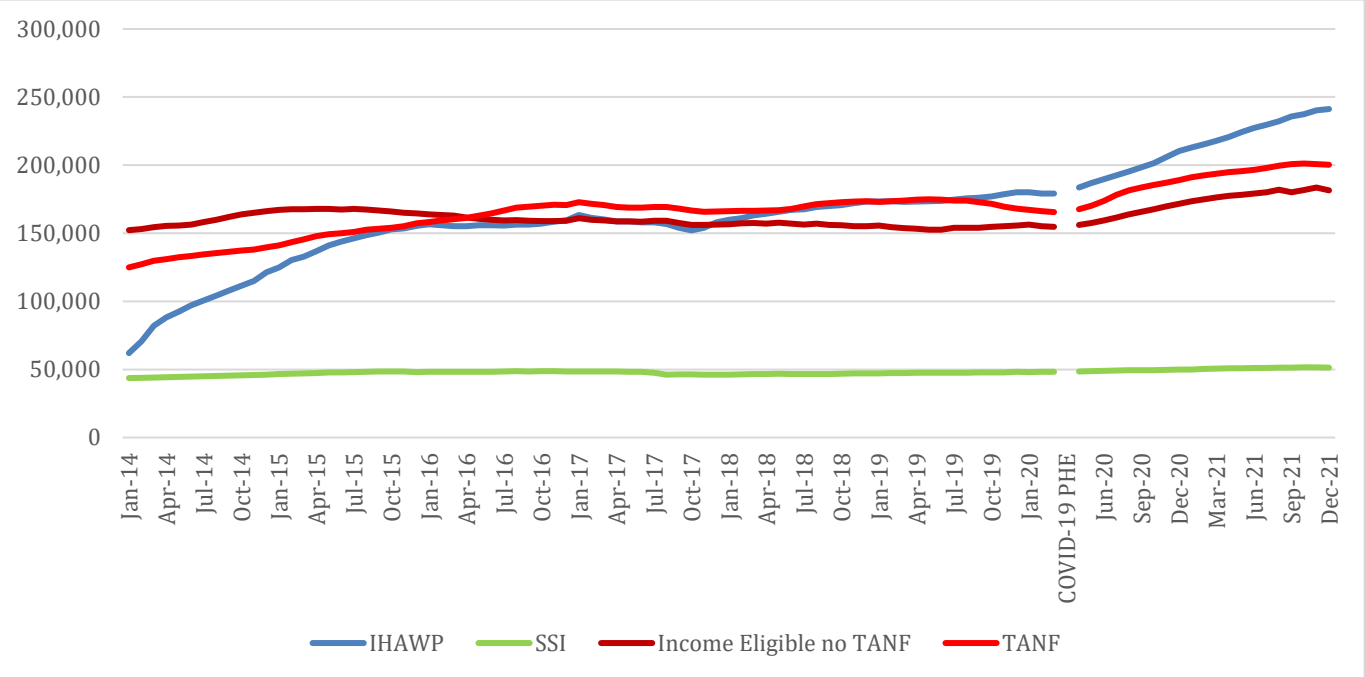
The eligibility adjustments related to the federal PHE prevented Medicaid members from being disenrolled for any reason including non-payment of premiums or non-completion of Healthy Behaviors.

The following notification was provided to members:

> *No one will be disenrolled or have their Medicaid services reduced due to an inability to pay a premium, incomplete Healthy Behaviors, or other means throughout the duration of the COVID-19 pandemic. (Disenrollment will still occur for those who are no longer a resident of Iowa, deceased, or requested benefits to be canceled.)*[1]

This resulted in members experiencing longer periods of enrollment without disruption. Additionally, we expected that more people would enroll for Medicaid as people who were unable to maintain employment sought help to pay for healthcare. Figure 1 portrays the increase in Medicaid membership following the COVID-19 Public Health Emergency declaration for 4 groups of Medicaid members: 1) IHAWP, 2) SSI – adults provided Medicaid coverage through a disability determination, 3) Income Eligible no TANF – includes adults and children eligible through programs directed to mothers and children and 4) TANF – adults as members of families eligible for Temporary Assistance to Needy Families.

Figure 1. Number of Medicaid members per month by program
January 2014 – December 2021



[1] No Medicaid Disenrollments or Reduced Services During COVID-19 Pandemic | Iowa Department of Human Services, accessed 12/1/2021

Two factors affect the rising number of Medicaid members per month. First, enrollments may increase to include people who are losing jobs and/or benefits due to the pandemic. Second, the curtailment of disenrollment allows people to retain coverage.

Membership changes over time

Figure 2 provides some insight into the mechanism at work by showing the number of members moving into and out of Medicaid and Medicaid programs.

G*ray – Not in a Medicaid program.*

Red – Marketplace Choice (Folded into Iowa Health and Wellness Plan December 31, 2015)

Yellow – Iowa Health and Wellness Plan

Dark blue – IowaCare (ended December 31, 2013)

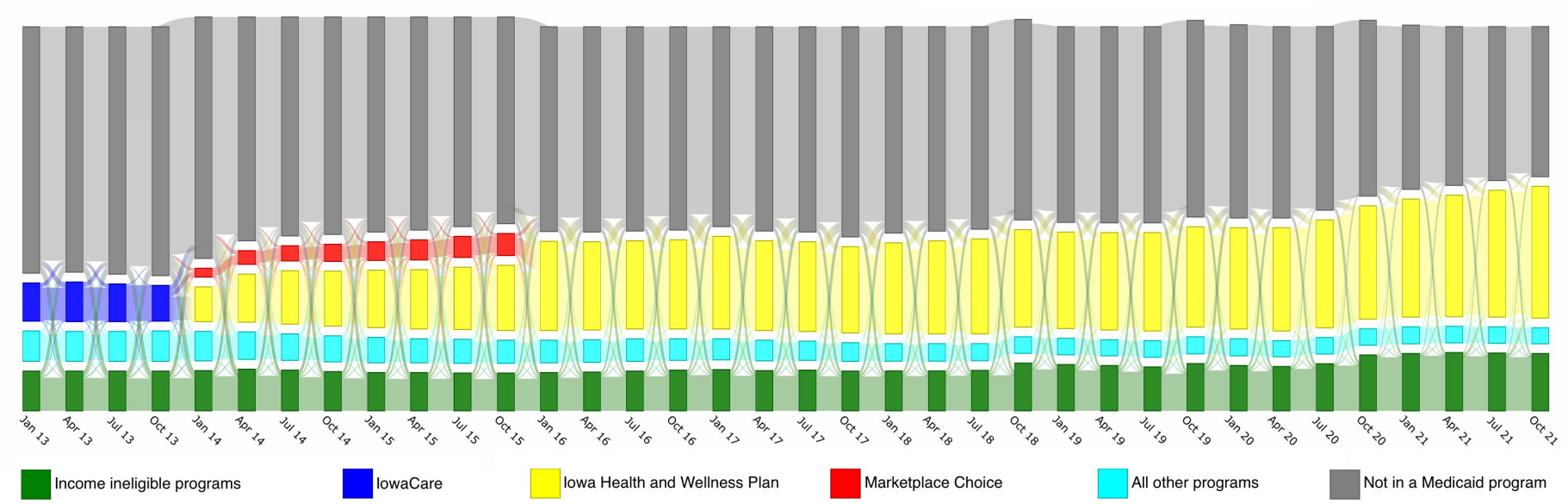
Green – Income eligible programs such as MAC – medical assistance to Mothers and Children

Teal – All other programs.

We focus particularly on the grey, those not in Medicaid, and the yellow, those in Iowa Health and Wellness Plan with attention paid to the lines moving from grey to yellow and yellow to gray.

Lines moving from grey to yellow (left to right) represent the number of people entering Iowa Health and Wellness Plan after having no Medicaid-funded coverage option, while those lines moving from yellow to grey (left to right) represent those moving out of Iowa Health and Wellness Plan to having no Medicaid-funded coverage. We are interested in the period immediately before and during the pandemic. During the time prior to the pandemic, these two lines are even and fairly thick meaning that as many members were entering as were leaving Iowa Health and Wellness Plan. After April 2020, during the pandemic, the line moving from no coverage to Iowa Health and Wellness Plan remains similar to the pre-April pattern; however, the line moving from Iowa Health and Wellness Plan to no coverage nearly disappears. This indicates that we are not seeing more people entering Iowa Health and Wellness Plan (these numbers are staying relatively stable), but there are far fewer members leaving Iowa Health and Wellness Plan, as one might expect given the suspension of disenrollment.

Figure 2. Movement of enrollees into and out of Medicaid programs by quarter
First quarter 2013 – fourth quarter 2021



To assess whether there are increases in the number of people applying for and receiving Medicaid coverage, we determined the number of new members per month for the period one year prior to the PHE (March 2019) through December 2021.

New – Member who became enrolled in Medicaid and had no Medicaid-funded coverage in the previous year.

Disenrolled – Member who is not covered for at least 6 months following loss of coverage.

IHAWP – Iowa Health and Wellness Plan

IE – Income eligible members 19-64 years of age

SSI – Disability determination eligible members 19-64 years of age

Generally, Figure 3 shows that, generally there were no increases in new enrollees from April 2020 through December 2021 as compared to the pre-PHE period (March 2019-March 2020). This suggests that the increased member numbers over time are due to members remaining on the program longer. This is evident in Figure 4. The number of members disenrolled drops sharply in April 2020, at the beginning of the PHE and does not increase over time.

Figure 3. Number of new members per month by program
March 2019 – December 2021

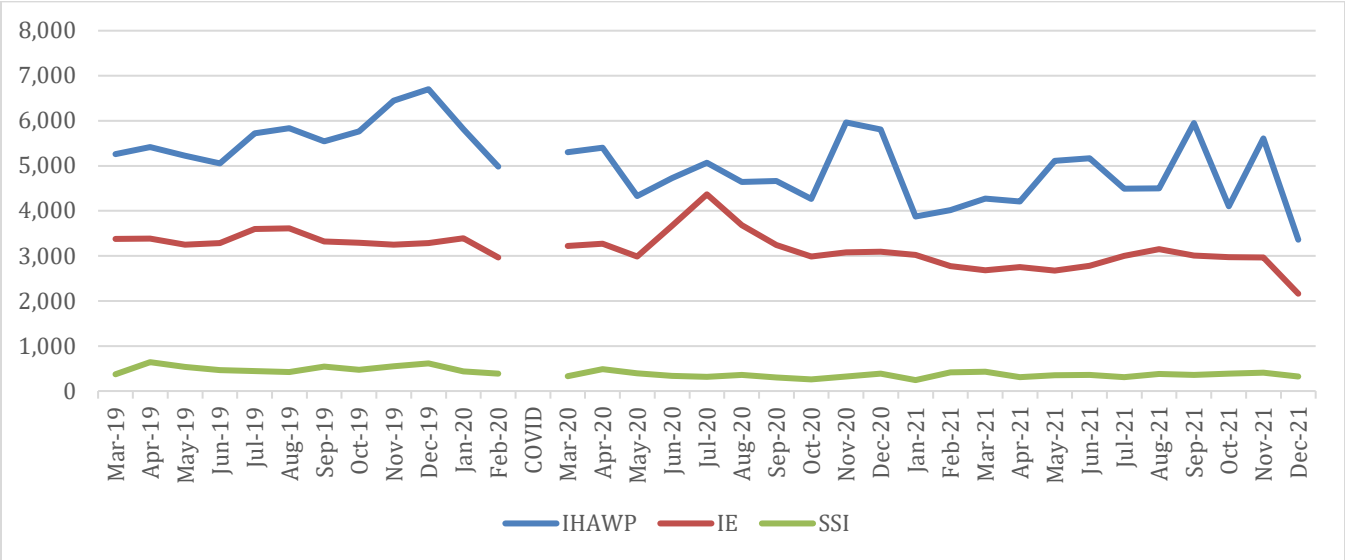
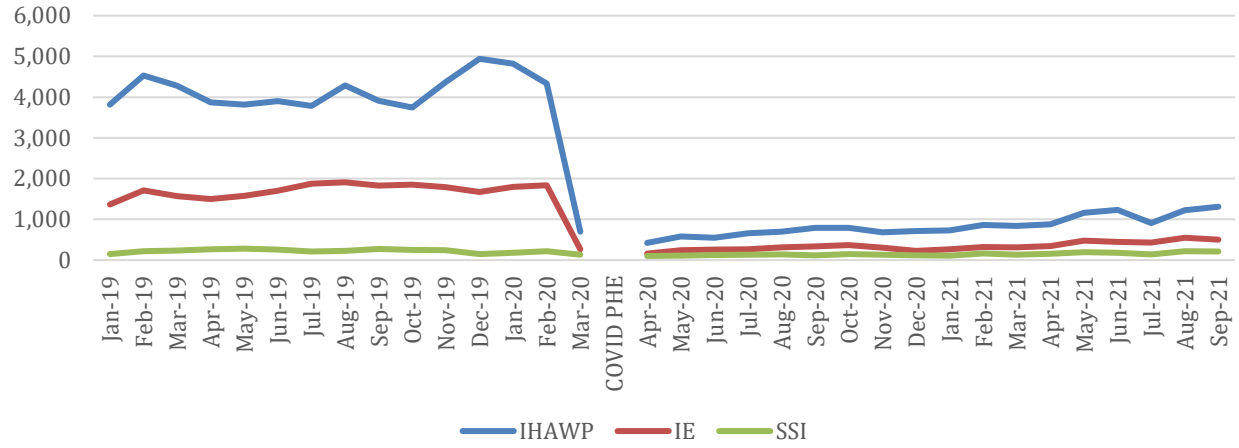


Figure 4. Number of members disenrolled by program and month
March 2018 - September 2021



Churn

Medicaid member churn describes the movement of individuals in and out of the Medicaid program. Figure 2 provides a visualization of the changes in membership over time, highlighting the increased membership and reduced churn during the PHE. Further evidence of the stability in membership during the PHE is discussed below.

Study period – March 2018 through December 2020.

Program – Medicaid program member was enrolled with at beginning of churn event (switch, gap).

Study groups – Members who were enrolled in Iowa Health and Wellness Plan (IHAWP) or due to income eligibility (IE) or due to a disability determination (SSI) at the time that the churn occurred.

*Switch – A change in program **without a gap** in coverage.*

Gap – A period of Medicaid coverage lapse lasting at least one month with coverage before and after the non-covered period.

Coverage switches

Medicaid members may switch programs for a variety of reasons including a changes in health care needs leading to reduced income or increased disability, changes in economic situation such as increased income or reductions in paid time, or alterations in household composition with the addition of a new child, divorce or death.

Switches are considered successes of the program as they allow coverage to continue as member circumstances change. In particular, movement from the income eligible programs to the Iowa Health and Wellness Plan (IHAWP) provides evidence of members being able to maintain coverage as they increase their income.

There were 82,907 Medicaid members who switched: 48,366 in IE, 3,981 in SSI, and 30,560 in IHAWP. There was a total of 103,689 switches with 56,820 from IE, 5,680 from SSI, and 41,189 from IHAWP. The distribution of switches by year is shown in

Figure 5. Program switches by year
March 2018-December 2020

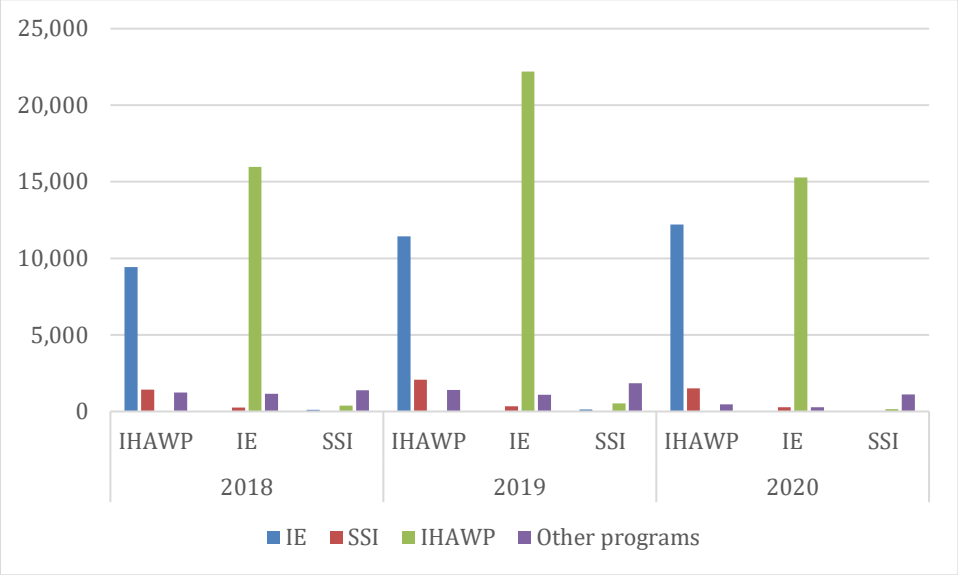


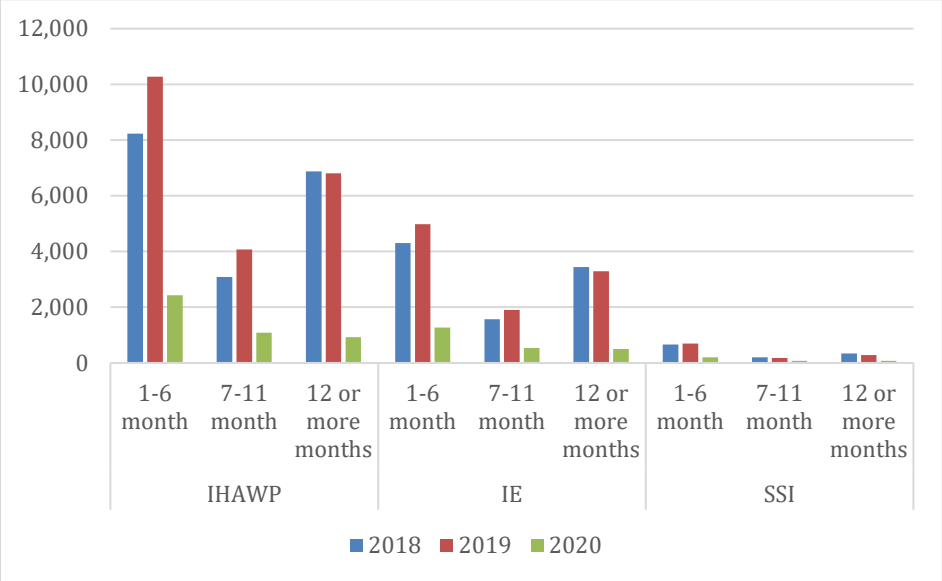
Figure 5 shows that most switches either occur from IHAWP to an IE program or from and IE program to IHAWP, even during the PHE. Members in SSI normally switch to another coverage option such as dual eligibility with Medicare or the Medicaid for Employed People with Disabilities (MEPD).

Coverage gaps

Within the Medicaid program, gaps in coverage may arise for many reasons, however, one primary reason for a gap in coverage may result from members not providing needed documentation regarding eligibility such as income information. When there is little or no immediate need for care the time and effort required to gather documentation may be overwhelming compared to the other needs of an individual or family. The PHE halted all disenrollment except as requested by a member.

There were 64,204 members who had at least one gap during the period March 2018 through December 2020. Of these, 20,355 were in IE, 2,589 were in SSI, and 41,260 were in IHAWP. Medicaid members experienced 68,303 gaps with 21,801 for IE members, 2,709 for SSI members, and 43,793 for IHAWP members. Figure 5 shows the gaps by length, program and year. The outcome of the PHE is clear in the significant reduction in gap numbers and length during CY 2020.

Figure 6. Gap length by program and year
March 2018 - December 2020



Conclusion

The PHE flexibility allowed Medicaid members to remain covered throughout the PHE unless they requested disenrollment, were no longer residents of Iowa, or died. This report provides descriptive data and visualization of the enrollment and churn for Medicaid members before and during the PHE. Though the number of new enrollees per month did not increase significantly over time, the number of enrollees with continued coverage did. PHE flexibilities provided a 'safe harbor' of coverage for Medicaid enrollees allowing them to remain covered but allowing them to move between programs as appropriate.

Appendix A

Department of HUMAN SERVICES

Iowa Medicaid's Response to COVID-19

Executive Summary

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 the COVID-19 federal public health emergency. There were also a number of flexibilities that the Department was 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 PHE, which is currently scheduled to expire on January 20, 2021. This is a high-level summary of some of the Department's response to COVID-19 and is not all-inclusive.

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 the PHE.
COVID-19 testing for uninsured	• Uninsured individuals who wish to be tested for COVID-19 can apply for COVID-19 Testing medical coverage. • The application is available 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, including doctor visits, hospital care, or prescriptions.
Expanded telehealth services	• Prior to COVID-19, Iowa Medicaid allowed telehealth for members if they were in certain originating sites like 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. • All telehealth services are currently paid at parity to face-to-face visits. • Expanded telehealth will be in place through at least the end of the PHE.

Expanded home delivered meals, homemaker, and companion services	• Due to COVID-19, the Department expanded home delivered meals, homemaker and companion services to all current members receiving HCBS or habilitation services and Medicaid members who are home bound due to COVID-19.
Extended prior authorizations (PAs) for elective procedures that were delayed/cancelled	• PAs for Medicaid members were not waived during the pandemic, nor were PAs extended for continuity of care. • The Department did extend PAs that were approved by the MCOs, dental plans, or the Department for Fee-for-Service, for elective procedures that were delayed or cancelled in March through May due to COVID-19. • Department approved; did not need CMS approval.

Provider Response	
Answering questions from providers	• A dedicated email address was created to collect and track questions from providers (IMECOVID19@dhs.state.ia.us). • A new COVID-19 Frequently Asked Questions (FAQs) section was added to the DHS website and updated regularly. • All of the FAQs were put into a provider toolkit that could easily be downloaded and shared. • The Department continues to hold regular calls with providers and other stakeholders to answer COVID-19-related questions.
Extended timely filing deadline 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. • Fee-for-Service and dental timely filing is at 365 days and remains unchanged right now. • Department approved; did not need CMS approval.
Civil Money Penalties grant for nursing facilities	• Nursing facilities can apply for grants to purchase communicative technology devices (like iPads, tablets or webcams) for residents to use or funds for in-person visitation aids (tents for outdoor visitation and/or clear dividers to create physical barriers) during the PHE. • Grants are up to $3,000 per facility for technology devices and in-person visitation aids. Facilities can apply for both. • Facilities are reimbursed after submitting receipts to the Department. • Applications are accepted through the end of the PHE.

Retainer payments for Home- and Community-Based (HCBS) and Habilitation providers	• These providers were able to bill the Managed Care Organizations (MCOs) for retainer payments for certain services they 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.
CARES Act relief grants for HCBS, mental health (MH), and substance use disorder (SUD) providers	• The Department distributed $50 million in CARES Act grants to HCBS waiver and habilitation direct service providers, MH, and SUD service providers to help offset impacts of the COVID-19 pandemic. • Of the $50 million, $30M went to HCBS, $10M went to MH, and $10M went to 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.
Enhanced dental payment	• As part of the PHE, 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 Fee-for-Service dental claims.
COVID-19 Relief Rate Add-on payment for nursing facilities	• Available to Medicaid certified skilled nursing facilities and nursing facilities during the period of 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. • 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.

Temporary suspension of prior authorization (PA) requirement for inpatient discharges to post-acute providers	• In an effort to provide support for healthcare system capacity during a surge in COVID-19 cases, the Department worked with the MCOs to suspend the PA requirement for patients who are discharged to post-acute providers. • This was effective starting November 17, 2020, for both MCOs. • This is a temporary change.
Grants for Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs), Psychiatric Mental Institutions for Children (PMICs), and Nursing Facilities (NFs)	• On December 7, 2020, the Department provided grants to Medicaid-enrolled Community-Based ICF/IDs, PMICs, and NFs 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 in CARES Act grants was given to ICF/IDs and PMICs; $14 million was given to NFs. • Each facility needed to complete an online attestation to keep the grant. • If the facility doesn't want the grant, or doesn't complete the attestation, the Department will begin recouping the grants in January.