State/Territory: Iowa

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Iowa's Medicaid state plan, as described below:

State/Territory: Iowa

Iowa's Medicaid state plan generally requires the State to provide tribal notification 60 days before any submission to CMS. However, due to the emergency nature of the requests Iowa has made to CMS to address the COVID-19 national emergency, the State requests that CMS waive the requirement of tribal notice prior to CMS submission. The State provided a notice of COVID-19 related requests to federally recognized tribes, Indian Health Programs and Urban Indian Organizations within the State of Iowa on April 1, 2020. To the extent future modifications to the State Plan or waivers are required in response to COVID-19, the State will provide tribal notice as expeditiously as possible and no later than within 15 days of CMS submission.

Section A – Eligibility

1. X The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

The State is requesting authority to provide coverage to the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act to provide coverage for COVID-19 testing for uninsured individuals effective March 18, 2020. There is no income or resource standard for this group.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. X The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. X The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Iowa requests flexibility to allow hospitals to make presumptive eligibility determinations for: (1) Individuals Eligible For But Not Receiving Cash Assistance--1902(a)(10)(A)(ii)(I); 42 CFR 435.210; (2) Individuals in Institutions Eligible Under a Special Income Level--1902(a)(10)(A)(ii)(V); 42 CFR 435.236; and (3) Medicaid for Employed People with Disabilities (MEPD)--1902(a)(10)(A)(ii)(XIII) during the national emergency. Periods of presumptive eligibility are limited to no more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period. All applicable hospital presumptive eligibility performance standards will be applied.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. __X__ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Iowa has suspended all cost sharing for all services and all beneficiaries during the COVID-19 national emergency.

2. __X__ The agency suspends enrollment fees, premiums and similar charges for:

   a. __X__ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. __X__ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

For individuals receiving services state plan home and community based services (HCBS) under Iowa's 1915(i) program, the State is adding:

Home-Delivered Meals
Service Definition (Scope): Home delivered meals are meals prepared elsewhere and delivered to a waiver member's residence. Each meal shall ensure the member receives a minimum of one third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National of the National Research Council of the National Academy of Sciences.

In addition to allowing this service to those who demonstrate need, the State also proposes to allow this service as an option to replace habilitation services that are unavailable if there is a shortage of providers or providers are not able to deliver goal directed services due to the COVID-19 emergency. The State assures that home delivered meals do not duplicate any other Medicaid services rendered to a member and that providers delivering this service are not also providers of the same services for the same individuals receiving the home delivered meals.

Limits: A maximum of 14 meals is allowed per week; no more than 2 meals will be provided per day. A unit of service is a meal. Services will be included in the member's care plan and monitored by the service worker. Available for 1915(i) enrollees who are homebound due to the COVID-19 emergency.

Provider Specifications: Legally responsible persons and relatives/legal guardians may provide the service, in addition to the following provider types.

Home Health Agency: Certified as a home health agency under Medicare; or authorized to provide similar services through a contract with the Iowa Department of Public Health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

Home Care Agency: Certified as a home health agency under Medicare; or authorized to provide similar services through a contract with the Iowa Department of Public Health (IDPH) for local

public health services. The agency must provide a current IDPH local public health services contract number.

Restaurants: Licensed and inspected under Iowa Code Chapter 137F.

Hospitals: Enrolled as a Medicaid Provider as described in IAC 441 Chapter 77.3. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program are eligible to participate but may be subject to the additional requirements of the rule.

Assisted Living Facility: Assisted living programs that are certified by the Department of Inspections and Appeals under 481—Chapter 69. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Case managers or community based case managers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Subcontractor with Area Agencies on Aging: Home-delivered meals providers subcontracting with Area Agencies on Aging or with letters of approval from the Area Agencies on Aging stating the organization is qualified to provide home-delivered meals services.

Community Action Agency: Community action agencies as designated in Iowa Code section 216A.93. Contracting agencies are responsible to ensure that the contractor is qualified and reliable. Service workers are responsible to monitor service provision to ensure services are provided in a safe and effective manner.

Nursing Facility: Licensed pursuant to Iowa Code Chapter 135C and qualifying for Medicaid enrollment as described in IAC 441 Chapter 81.

Area Agencies on Aging: Area Agencies on Aging as designated according to Department on Aging rules IAC 17—4.4(231).

Medical Equipment and Supply Dealers: Medical equipment and supply dealer certified to participate in the Medicaid program as defined by IAC 441 Chapter 77.10. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

Verification of Provider Qualifications: The Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit verifies provider qualifications for the aforementioned providers every four years.

Companion Services

Service Definition (Scope): Non-medical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparations, laundry, shopping and light housekeeping tasks. This service cannot provide hands on nursing or medical care. The light housekeeping tasks are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

This service cannot be duplicative of any other service under the state plan or waiver. The case manager, community-based case manager (CBCM), or integrated health home care coordinator is responsible for authorizing the service and ensures that companion services do not coincide with similar services. In addition, the case manager, CBCM, or integrated health home care coordinator is responsible to ensure that each provider understands the scope and timeframes for authorized tasks.

In addition to allowing this as a service to those who demonstrate need, the State also proposes to allow this service as an option to replace habilitation services that are unavailable if there is a shortage of providers or providers are not able to deliver goal directed services due to the COVID-19 emergency.

Limits: Services must be authorized in the service plan and monitored by the Case Manager.

Provider Specifications: Legally responsible persons and relatives/legal guardians may provide the service, in addition to the following provider types.

Corporation for National and Community Services: Must meet the requirements per IAC 441-77.33(14) and are required to follow the Federal regulations, published in Title 45, Chapter XXV, Section 2551, of the Code of Federal Regulations (CFR).

Senior Companion: Must meet the requirements per IAC 441- CH 77.

Supported Community Living: Must meet the requirements per IAC 441- CH 77.

Respite: Must meet the requirements per IAC 441- CH 77.

Consumer Directed Attendant Care: Must meet the requirements per IAC 441- CH 77.

Day Habilitation: Must meet the requirements per IAC 441- CH 77.

Senior Companion: Must meet the requirements per IAC 441- CH 77.

Verification of Provider Qualifications: The Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit verifies provider qualifications for the aforementioned providers every four years.

Homemaker Services

Service Definition (Scope): Homemaker services are services that are provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. Components of the service are directly related to the care of the members and may include: essential shopping, limited house cleaning and meal preparation. Services cannot be duplicative of another service. The Case Manager is responsible for monitoring service provision on an ongoing basis.

In addition to allowing this as a service to those who demonstrate need, the State also proposes to allow this service as an option to replace habilitation services that are unavailable if there is a

shortage of providers or providers are not able to deliver goal directed services due to the COVID-19 emergency.

Limits: A unit of service is 15 minutes. The members' plan of care will address how the member's health care needs are being met. Services must be authorized in the service plan to be monitored by the Case Manager.

Provider Specifications: Legally responsible persons and relatives/legal guardians may provide the service, in addition to the following provider types.

Home Health Agencies: Home health agencies are eligible to participate provided they are certified to participate with the Medicare program (Title XVIII of the Social Security Act sections 1861(o) and 1891).

CDAC Agency: Must meet the requirements per IAC 441- CH 77.

Verification of Provider Qualifications: The Iowa Department of Human Services, Iowa Medicaid Enterprise, Provider Services Unit verifies provider qualifications for the aforementioned providers every four years.

Policies Concerning Payment for State Plan HCBS Furnished by Relatives, Legally Responsible Individuals and Legal Guardians.
The State assures there are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. A person who is legally responsible for, or a guardian of, a participant may provide services to a 1915(i) participant. Homemaker, companion services and home-delivered meals may be provided by persons who are legally responsible; the service planning team determines the need for and the types of activities to be provided by the legally responsible person. This includes reviewing if the needed services are "extraordinary." Any services which are activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and are not necessary to assure the health and welfare of the participant and to avoid institutionalization would not be considered extraordinary. The relative or legal guardian must have the skills needed to provide the services to the participant and must meet the 1915(i) service provider qualifications as specified in the approved 1915(i) State Plan HCBS benefit. Case Managers remain responsible for oversight and implementation of the service plan. The IME CORE unit and the MCOs will need to identify the processes and procedures to assure claims payment.

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. X The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. X Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. X Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. X The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

During the COVID-19 emergency, the State will add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for the following 1915(i) services: 1. Case management 2. Habilitation including the following habilitation service components: Home-Based Habilitation, Day Habilitation , Prevocational, and Supported Employment 3. Monthly monitoring (i.e., in order to meet the reasonable indication of need for service requirements in 1915(i) state plan) 4. 1915(i) eligibility evaluations/reevaluations 5. Independent assessments/reassessments of need. The State assures compliance with 42 CFR 441.720(a)(1)(i). 6. Completion of Person Center Service Planning Meetings. Additionally, the State will allow telehealth services to be provided, regardless of the recipient's location, for all Medicaid-covered benefits if provision of the service via telehealth is clinically feasible and appropriate.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. __X__ Newly added benefits described in Section D are paid using the following methodology:

   a. __X__ Published fee schedules –

   Effective date (enter date of change): Varies by service, the effective date of the applicable fee schedule for each added service is outlined here: https://www.legis.iowa.gov/docs/iac/chapter/441.79.pdf. This SPA is effective for 1915(i) services provided on or after March 1, 2020 until the end of the PHE.

   Location (list published location): All fee schedules are here: http://dhs.iowa.gov/ime/providers/csrp. All HCBS services discussed in Section D. Benefits are currently authorized as 1915(c) services. The state is proposing to offer the same services as 1915(i) state plan service during the PHE. All 1915(i) services will use the same methodology as their 1915(c) counterparts, as described at https://www.legis.iowa.gov/docs/iac/chapter/441.79.pdf, effective March 1, 2020.

   b. _____ Other:

   Describe methodology here.

State/Territory: Iowa

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

State/Territory: Iowa

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. _____ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

State/Territory: Iowa

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

In addition to the modifications to its 1915(i) program identified in Section D – Benefits, Iowa will amend its 1915(i) program to add an electronic method of signing off on required documents such as the person-centered service plan.

Potentially expand State Plan HCBS as follows, if necessary and appropriate: allow services to be provided in facility settings when the individual is quarantined within the facility due to COVID-19 or when the facility placement is appropriate due to the community provider limitation to provide services and for the health and safety of the member due to COVID-19; 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; and, lift the existing limitation on 5 person homes to no longer designate an upper limit to allow providers to consolidate members into homes, with this allowance limited by the home's capacity. The State ensures that HCBS provided in facility settings will not duplicate services regularly provided by the facility.

The State requests to 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.

Additionally, the State is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services when the case management entity is the only willing and qualified entity to perform the independent assessment and develop the person-centered service plan. Therefore, the case management entity qualifies under 42 CFR 441.730(b)(5) as the only willing and qualified entity. The case management entity will have to meet the provider qualifications for the direct services they wish to provide.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims,

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