Department of HUMAN SERVICES

**INFORMATIONAL LETTER NO. 2246-MC-FFS-CVD**

**DATE:** July 23, 2021

**TO:** All Iowa Medicaid Providers

**APPLIES TO:** Managed Care (MC), Fee-for-Service (FFS), and Coronavirus Disease (CVD)

**FROM:** Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

**RE:** Unwinding COVID-19 Medical Assistance Eligibility Update

**EFFECTIVE:** Immediately

As detailed in Informational Letter (IL) 2229-MC-FFS-CVD[1], in April 2021, DHS began using a phased approach to return to normal medical assistance eligibility processes in order to comply with the continued enrollment requirement under the Maintenance of Effort (MOE) provision of the federal Families First Coronavirus Response Act (FFCRA). As previously outlined in IL 2229-MC-FFS-CVD, the unwinding of Medicaid COVID-19 flexibilities will occur in five phases over several months.

Details regarding the first three phases follows. The remaining phases will start at the conclusion of the federal Public Health Emergency (PHE). The Department is still determining what will be included in these phases.

**Phase 1**

Phase 1 was implemented on April 20, 2021, and included resuming some Medicaid eligibility operating procedures that did not require technical assistance. With the implementation of Phase 1, Medicaid will resume discontinuance of members that were approved for medical assistance in error, transition members to a coverage group they are now eligible for, and review eligibility for Hawki members who have turned 19 years old and no longer qualify for the Hawki program. These regular Medicaid eligibility procedures had been on hold since March 2020 due to the COVID-19 pandemic.

[1] https://dhs.iowa.gov/sites/default/files/2229-MC-FFS-CVD_Unwinding_COVID-19_Medical_Assistance_Eligibility.pdf

**Phase 2**
Phase 2 was implemented in June 2021. As part of Phase 2, Income Maintenance (IM) workers have started acting on changes for all Long Term Services and Supports (LTSS) cases. Some LTSS members, including those receiving Home- and Community-Based Services (HCBS) waivers and state plan HCBS habilitation services, Program for All-Inclusive Care for the Elderly (PACE), and facility coverage may be transitioned to a different Medicaid coverage group based on a review of circumstances. Members affected by Phase 2 were sent a letter[2] in the mail in June 2021 notifying them of an upcoming review.

After a review, if a member's LTSS coverage ends, LTSS services may no longer be covered for the member, but they may be able to continue to receive other medical services through Medicaid until the end of the PHE, or until Medicaid is given federal direction to evaluate this type of coverage, whichever should come first. If the member is on Medicare, their medical benefits will be provided by Medicare, but Medicaid may help cover the cost of their Medicare premiums. Affected members will be sent a notice in the mail saying they will be ineligible after the PHE has ended. A separate official notice will be issued to the member at the end of the PHE when their coverage is discontinued.

Additionally, Phase 2 includes:

- Resuming automated Medicaid system batch eligibility redeterminations for changes in household circumstances, and
- Completing an annual renewal/redetermination when acting on changes in household circumstances.
- Resuming system alerts that notify IM workers of pertinent program information known to the Department. IM workers will act on this information and complete a redetermination of eligibility, if appropriate.

**Phase 3**
Phase 3 is also now underway. Phase 3 includes issuing pre-populated annual medical assistance renewal/review forms to households. The first set of pre-populated forms were sent to members on June 22, 2021, for August 2021 eligibility. Pre-populated forms will continue to be sent to members each month. This allows DHS to begin working through the backlog of annual renewals now rather than waiting until after the PHE has ended, in order to maintain federal compliance.

Members who are deemed eligible for medical assistance upon their annual renewal month, will have their eligibility renewed for one year with a new renewal date. **Members who are found ineligible during this annual renewal process, will continue to receive medical assistance through the duration of the PHE**. Affected households will be sent a notice of action in the mail saying they are ineligible after the PHE has ended. A separate official notice will be issued to the household at the end of the PHE when their coverage is actually being discontinued.

[2] https://dhs.iowa.gov/sites/default/files/470-5662.pdf

**Most members will continue to maintain medical assistance eligibility throughout the PHE.**

Providers should continue to confirm member eligibility through the Eligibility and Verification Information System (ELVS).

If you have questions, please contact the IME Provider Services at **1-800-338-7909**, Monday – Friday from 7:30 a.m. to 4:30 p.m., or by email at imeproviderservices@dhs.state.ia.us.