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MEDICAID MEMO

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COVID-19 Flexibility Updates Through 4/20/2021

This memo sets out interim guidance from the Department of Medical Assistance Services (DMAS) to extend or discontinue federal and state authorities that allow regulatory flexibilities to providers during the public health emergency presented by COVID-19.

This memo is an update on certain flexibilities and as more information is received on the federal and state public health emergencies, DMAS will provide additional updates through future memos.

Providers are encouraged to frequently access the DMAS website to check the central COVID-19 response page for both frequently asked questions (FAQs) and guidance regarding these flexibilities, as well as ongoing flexibilities for behavioral health and addiction recovery treatment services, at http://www.dmas.virginia.gov/#/emergencywaiver. For additional questions about this memo or other COVID-19 related issues, the agency has created a centralized point of access for submission at http://dmas.virginia.gov/contactforms/#/general Questions may also be submitted to COVID-19@dmas.virginia.gov

Background on Federal and State Authorities

Certain flexibilities are permitted to be in effect only during the federal public health emergency. The federal public health emergency was recently extended to April 20, 2021. At the state level, Virginia Executive Orders (EO) 51 and 58 provide corresponding policy flexibilities associated with the state public health emergency declaration. The Virginia Executive Orders currently do not have an expiration date.

Most flexibilities depend on both state and federal authorities. DMAS is required to unwind the flexibilities obtained when either the federal or the state emergency declarations expire. Only flexibilities extended by the federal public health emergency are contained in this memo. Additionally, this memo addresses two appeal flexibilities that are being ended. Normal DMAS policies and procedures are in effect for any flexibilities not discussed in this memo.

Eligibility and Enrollment:

With the announcement of the extension of the federal Public Health Emergency (PHE), continuity of coverage must remain until April 30, 2021 for Medicaid members. No closures or adverse action will be taken on Medicaid enrollments through the end of the emergency unless a death is reported, an enrollee moves from Virginia permanently, or an enrollee requests closure of coverage. Individuals who become incarcerated must have their coverage reduced to cover inpatient services only.

Federal continuity of coverage requirements do not apply to lawfully residing non-citizen pregnant women or children under age 19. Additionally, the continuity of coverage requirements do not apply for coverage in a separate Children's Health Insurance Program (CHIP) program. In Virginia, this includes Family Access to Medical Insurance Security (FAMIS) MOMS pregnant women whose

sixty (60) day post-partum period has ended, and FAMIS children turning

19. Individuals who meet these requirements and have reached age 19 or who have reached the end of their pregnancy period will be re-determined and enrolled in other coverage or, if no longer eligible, referred to the Federal Marketplace for coverage options.

Nursing Facilities

Per provision 313.LLLLL in the 2020 Special Session I Amendments to the 2020 Appropriation Act, the additional $20 per diem payment for nursing facilities and specialized care facilities shall continue through the current biennium, June 30, 2021. The enrolled Budget proposes an additional extension into FY2022 and the creation of a value-based program. DMAS will provide additional information about these provisions if they are in the final adopted Budget.

DMAS will continue to extend the following flexibilities until April 20, 2021:

1. Suspend Pre-Admission Screening and Resident Review (PASRR) Level I and Level II Assessments for 30 days. Note: This applies to nursing facility admissions only. Those choosing home and community based options for care must still have a completed screening for Long Term Services and Supports (LTSS). Such screenings shall be conducted either through telehealth or telephone services.
2. Waive 42 CFR 483.20(k) allowing nursing facilities to admit new residents who have not reached Level 1 or Level 2 of the PASRR. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing facilities with potential mental illness, intellectual disability, or related condition must be referred promptly by the nursing facility to state PASRR program for a Resident Review.
3. Extend minimum data set authorizations for nursing facility and skilled nursing facility (SNF) residents.
4. Waive the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a skilled nursing facility (SNF) and nursing facility (NF) may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d).
5. Waive the requirement for the Medicaid LTSS Screening for individuals admitted to a nursing facility directly from hospital inpatient status.
6. Medicaid LTSS Screenings will continue as requested and needed for the Commonwealth Coordinated Care (CCC) Plus Waiver, the Program of All Inclusive Care for the Elderly (PACE), and nursing facility admissions directly from the community.
7. Community-based and hospital LTSS Screeners may continue to accept verbal consent on the Individual Choice Form, DMAS-97 verified by two witnesses.
8. Community-Based Teams may continue to conduct LTSS Screenings using telehealth methods. Community screenings must be completed within 30 days of the initial request.
9. Health Plans experiencing difficulty enrolling individuals for nursing facility care or changing nursing facility level of care, may attach the DMAS-80 to a secure email sent to CCCPlusmcos@dmas.virginia.gov. The DMAS-80 will be reviewed by DMAS staff and assistance provided.

<u>Patient Pay:</u>

LTSS providers, please note that eligibility workers are unable to process increases in patient pay at this time due to the PHE.

Home Health and Hospice:

DMAS will extend the following flexibilities until April 20, 2021:

1. Waive the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks to evaluate if home health aides are providing care consistent with the care plan.
2. Suspend the two-week aide supervision by a registered nurse or licensed therapist for home health agencies. In lieu of a face-to-face supervisory visit, the nurse or licensed therapist may conduct the supervisory visit by telephone or via video communication. The nurse is
3. required to contact the home health aide or the member/caregiver to set up the supervisory visit.
4. Home health agencies may perform certifications, initial assessments, and determinations of a patient's homebound status remotely by telephone or via video communication in lieu of a face-to-face visit. Alternatively, a home health agency may conduct a record review if the record review fully and accurately describes the member's needs. A combination of telephone or video calls, if available, and record review should be considered when performing these functions. These actions will decrease member/caregiver contact with staff by increasing social distancing. Once a plan of care is established or revised, the agency can determine what staff is necessary to carry out the plan of care.
5. Waive the requirements at 42 CFR §418.76(h), which require a nurse to conduct an onsite supervisory visit every two weeks to evaluate if hospice aides are providing care consistent with the care plan. In lieu of a face-to-face supervisory visit, the registered nurse may contact the individual by telephone or via video communication. The nurse is required to contact the home health aide or the member/caregiver to schedule the supervisory visit.

Durable Medical Equipment (DME):

DMAS will extend the following flexibilities until April 20, 2021:

1. DMAS will allow the National Coalition for Assistive and Rehab Technology (NCART) recommendations for remote protocol, for complex rehab equipment, which allow only one member of the evaluation team meet face-to-face with the member for evaluations. The evaluation team should include a licensed therapist and an Assistive Technology Professional.
2. DMAS will allow the use of telehealth visits for therapy evaluations unless it is determined a face-to-face evaluation is warranted. The therapist performing the evaluation must be able to determine the appropriate DME via telehealth.
3. DMAS is temporarily waiving the face-to-face requirement for durable medical equipment for the list of codes published by Medicare and listed in the Durable Medical Equipment and Supplies Manual, Chapter IV.
4. DMAS will allow temporary coverage for short-term oxygen use for acute conditions.
    1. Members who are being discharged home to clear hospital beds in preparation of the hospital overflow issues. A written, faxed or verbal order from the practitioner is required for short-term oxygen to include diagnosis, flow rate and length of need.

2. Members who are being treated at home to prevent a hospital admission. A written, faxed or verbal order from the practitioner is required for short-term oxygen to include diagnosis, flow rate and length of need.

5. Certificate of Medical Necessity (CMN)
    1. Current CMNs: DMAS will allow a temporary extension of current CMNs until the end of the state of emergency. This will extend a current CMN from the end of the normal CMN validity time frame to the end of the state of emergency. This action should decrease the documentation burden on providers and practitioners. The DME provider can use the temporary extension to request an extended service authorization if required.
    2. For new orders: DMAS will allow a temporary suspension of the requirement for a CMN for new orders. The suspension of CMN requirement for new orders will be in effect starting April 13, 2020 and will end at the end of the state of emergency. CMN documentation will not need to be developed retroactively to cover the period during the state of emergency.
        1. The DME provider must have a written, faxed, emailed or verbal order from the practitioner that includes the members name, item(s) is being ordered and a diagnosis.
        2. Verbal orders must be documented in the member's record with the name of the ordering practitioner, date and time of the call and name of staff accepting the order. If the verbal order is given by a member of the practitioner's staff on behalf of the ordering practitioner, the DME provider must also document the name of the caller giving the verbal order on behalf of the ordering practitioner.
        3. For disposable supplies: The DME provider must document, in the member's chart, quantity and frequency of use if it is not included on the order. This can be obtained via fax or email from the practitioner's office.
        4. For new orders, after the end of the state of emergency, a valid CMN will be required for all DME and Supplies.
6. Due to industry concerns of supply chain disruptions, DMAS is instructing DME providers to only deliver one month of supplies at a time during the COVID-19 PHE. This is a policy change from the published memo by DMAS on 3/19/2020. DME providers must have contact with the member/caregiver via email, text, messaging service, video, phone, etc. to validate the member's need for refill supply orders before delivering supplies.
7. DMAS will waive in person signature requirements for home delivery of supplies until the end of the state of emergency. DME providers who are making home deliveries of supplies must be able to document delivery of supplies in lieu of an in person signature. Documentation of delivery can include a picture or text/email message from member/caregiver.

If a third party carrier is used for delivery of supplies the DME provider must continue to keep documentation of confirmed shipment receipt as proof of delivery.

Pharmacy:

DMAS will extend the following flexibilities until the end of the federal PHE declaration (April 20, 2020):

1. Suspend all drug co-payments for Medicaid and FAMIS members.
2. Coverage for a 90-day supply for all drugs excluding Schedule II drugs.

3. Waive requirements for pharmacies to collect a signature upon delivery or 'proof of delivery' from patients to prevent the spread of the novel coronavirus through contamination of pens or electronic signature devices. For those circumstances where there is no patient's signature, the pharmacist shall write "COVID19," "COVID," or substantially similar language as the equivalent to receiving a signature.

Behavioral Health and Addiction and Recovery Treatment Services (ARTS):

Note that new information in this section is in bold font and has been underlined.

This memo summarizes the Agency's guidance on the flexibilities available to Behavioral Health and ARTS providers in light of the federal and state PHEs presented by the COVID-19 virus. Any flexibilities granted under the federal PHE are extended until the end of the 60th day from the federal government notification that the PHE is ending.

Trauma Informed Care

Providers are encouraged to continue to provide interventions and formulate responses to

COVID-19 guided by trauma informed care (TIC) principles: trustworthiness, equity, choice, collaboration, empowerment, and safety. Providers are encouraged to consider these principles as they navigate the implementation of flexibilities outlined in this guidance.

Recommendations for Reducing Transmission

Please follow the guidance issued by the Department of Behavioral Health and Developmental Services (DBHDS), the Centers for Disease Control (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Virginia Department of Health (VDH).

Telehealth Services

DMAS is not requiring face-to-face delivery of Behavioral Health and ARTS services during the COVID-19 PHE. DMAS is allowing for telehealth (including telephonic) delivery of all Behavioral Health and ARTS services with several exceptions; these are differentiated below.

Allowable services via telehealth and telephonic delivery:

- Care coordination and targeted case management services;
- Peer Recovery Support Services;
- All service needs assessments (including the Comprehensive Needs Assessment (CNA), the Independent Assessment Certification, and Coordination Team (IACCT) assessment and the American Society of Addiction Medicine (ASAM) Multidimensional Assessment) and all treatment planning activities;
- Outpatient psychiatric services (this includes both medication management and psychotherapy services);
- Community Mental Health and Rehabilitation Services (CMHRS); and
- ARTS Levels of Care including the following:
    - substance use disorder intensive outpatient and partial hospitalization programs (ASAM Levels 2.1 and 2.5);

- opioid treatment services (Opioid Treatment Programs (OTPs) and Preferred Office-Based Opioid Treatment (OBOT));
- substance use disorder outpatient services (ASAM Level 1.0);
- early intervention services (ASAM Level 0.5);
- substance use disorder care coordination and targeted case management; and
- withdrawal management services.

Telehealth and Inpatient/Residential Settings

The applicable per diem or diagnostic related groups (DRG) rates for therapeutic group homes, psychiatric residential treatment facilities, ASAM Level 3.1 through 4.0 and inpatient psychiatric hospitalizations will not be billable through telehealth. The professional activities within these services including assessments, therapies (individual, group, and family), care coordination, team meetings, and treatment planning are allowable via telehealth.

Home as Originating Site

DMAS is allowing a member's home to serve as the originating site for members. This is particularly important for those who are quarantined, are diagnosed with and/or demonstrating symptoms of COVID-19, and/or are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. The originating site fee is not available for reimbursement when the patient's home is the originating site.

Documentation for Behavioral Health and ARTS Providers

Services delivered via telehealth (including telephonic communications) must have accompanying documentation in the member's record that states the alternative location used **for either the provider and/or the member**, and that the service was delivered via telehealth to support access to care during the PHE. The mode of delivery shall also be included in any new or subsequent service authorization requests.

DMAS recognizes that providers may have limited or no access to their offices, and members' physical records or other team members and that this may create barriers to obtaining necessary signatures on documentation. Thus, providers shall update documentation and treatment plans (including individual service plans (ISPs), interdisciplinary plans of care (IPOCs)) with at least notation that verbal or electronic consent was obtained. Provider and member verbal or electronic signatures are acceptable during the PHE. Providers need to ensure that the person "signing" is the intended individual, an authorized or someone acting responsibly for the individual. Providers are not required to obtain physical signatures of members when services are provided via telehealth or telephonic. Patient consents provided verbally or electronically are sufficient as long as documented (noted) in the member's record.

In regards to obtaining clinician signatures on relevant documentation, each provider shall make reasonable attempts to obtain signatures from the clinicians or document receiving the clinician's verbal **or electronic** consent or sign-off, with the name of the clinician and the date of receipt. If the clinician is unable to sign-off on documentation, the clinician shall maintain documentation of verbal consent or sign-off in their files.

Allowance of Face-to-Face Delivery of Group Services

As of July 1, 2020, DMAS resumed reimbursement for face-to-face delivery of group-based services. DMAS advises that providers carefully weigh the vulnerabilities and benefits of resuming face-to-face group services. Group-based providers are reminded that they retain, until further notice, the ability to offer services individually or through individual or group telehealth or telephonic contact. Providers are encouraged to prioritize the health and safety of members and their staff and to consider member preferences, engagement and optimal access to care. Providers who elect to provide face-to-face services should integrate guidance provided through the CDC, VDH, and any relevant licensing bodies.

For initial and continued stay reviews, a service authorization request shall be completed for those services that require a service authorization to verify medical necessity and appropriateness of the service delivery model.

Provider Qualifications and Licensure Requirements

Provider Types allowed to bill for Medicaid services will remain the same regardless of the delivery method (face-to-face vs. telehealth). Provider qualifications, licensure requirements, and the structure of the services shall remain intact. Thus Qualified Mental Health Professionals (QMHPs), Licensed Mental Health Professional (LMHP) Supervisees (LMHP-S), LMHP Residents (LMHP-R) and LMHP Residents in Psychology (LMHP-RP) must remain working under the direction of an LMHP. Licensed Behavior Analysts (LBA) and Licensed Assistant Behavior Analysts (LABA) must provide supervision to unlicensed staff (i.e. technicians) and LABAs must remain working under the direction of a LBA. Within the ARTS benefit, Certified Substance Abuse Counselors (CSAC) and CSAC-Supervisees must remain working under the direction of licensed providers authorized by the Board of Counseling.

Providers licensed in the state of Virginia, but located outside the state of Virginia, are allowed to provide telehealth services to individuals in Virginia. **If the member is temporarily located in another state, the licensed provider shall consult with the state the member is located to determine that state's specific requirements**. Virginia Medicaid allows for physicians (those licensed to practice medicine) who are actively licensed in states bordering Virginia but are not licensed in Virginia to continue to see their Virginia resident patients via telemedicine/telehealth or telephonic communications. The Board of Medicine requires that physicians must have an established relationship with the patient to meet this allowance.

Service Authorizations for Behavioral Health and ARTS

A 14-day grace period will be granted for the submission of Behavioral Health Authorizations within CMHRS, Assessments, Psychotherapies, Inpatient Treatment Services, and ARTS Levels of Care:

- Medicaid managed care organizations (MCOs) and Magellan of Virginia will allow up to 14 days after the start of a new behavioral health or ARTS service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO or Magellan of Virginia.
- This grace period does not waive medical necessity requirements for the services or other requirements currently set forth in policies for submissions of service authorization requests.
- This grace period does not guarantee payment.

Policy Flexibilities Applicable to Behavioral Health Services

- Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill-Building (MHSS), Intensive Community Treatment (ICT) and Psychosocial Rehabilitation (PSR).
    - Service delivery may be provided outside of the school setting, office setting, or clinic setting for the duration of the PHE.
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.
    - For youth participating in both TDT and IIH, TDT should not be used in person in the home as this would be a duplication of services. TDT may be provided through telehealth to youth receiving IIH (in person or via telehealth) as long as services are coordinated to avoid duplication and ensure efficacy of the treatment provided.
    - TDT providers licensed for school-based and non-school based care may provide services outside of the school, including during the summer, with their current license due to current needs to maintain social distancing. Providers are reminded that they must report to DBHDS Office of Licensing any changes to their programs that have occurred as a result of COVID-19.
    - The service authorization request for new services will be used to track which members are continuing to receive these services, assess the appropriateness of the services being delivered via different modes of treatment, and to determine if this is an appropriate service to meet the member's needs.
    - During the PHE, TDT, IIH, MHSS, ICT and PSR providers may bill for one unit on days when a billable service is provided, even if time spent in billable activities does not reach the time requirements to bill a service unit. This allowance only applies to the first service unit and does not apply to additional time spent in billable activities after the time requirements for the first service unit is reached. Providers shall bill for a maximum of one unit per day if any of the following apply:
        - The provider is only providing services through telephonic communications. If only providing services through telephonic communications, the provider shall bill a maximum of one unit per member per day, regardless of the amount of time of the phone call(s).
        - The provider is delivering services through telephonic communications, telehealth or face-to-face and does not reach a full unit of time spent in billable activities.
        - The provider is delivering services through any combination of telephonic communications, telehealth and in-person services and does not reach a full unit of time spent in billable activities.
    - Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.
    - Additional recommendations for TDT billing can be found on DMAS' COVID Response

website here:https://www.dmas.virginia.gov/files/links/5612/Therapeutic%20Day%20Treatment%20Service%20Delivery%20Recommendations%20during%20PHE.pdf

- Behavioral Therapy
  - Services are geared to be provided in settings that are natural or typical for the child or adolescent and may vary during the PHE. Behavioral Therapy may only be provided in the school setting (includes in–person or virtual learning) when the purpose is for observation and collaboration related to behavior and skill acquisition (not direct therapy) and services have been authorized by the school, parent and provider and included in the ISP.
  - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA.
  - One service unit equals 15 minutes for this level of care. Effective June 11, 2020, Behavioral Therapy providers do not have a one unit max limit per day for audio-only communications.
  - For Behavior Therapy services, a physician letter, referral, or determination is not required for submission of a service authorization. The MCO and Magellan of Virginia shall review the request and make a determination without the physician referral. The physician referral, letter or determination shall be completed within at least 60 days of the start of the service.
- Day Treatment/Partial Hospitalization Programs (PHP) for Adults
  - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA.
  - If providers are unable to provide the minimum amount of services required for the reimbursement of Day Treatment/PHP, providers may bill traditional outpatient psychotherapy, assessment, and evaluation codes.
  - Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than Day Treatment/PHP code.
  - Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.
- Crisis Stabilization/Crisis Intervention Services
  - The appropriateness of a crisis response using telehealth (including telephonic) shall be evaluated by the clinician and a determination shall be made by the clinician responding to the crisis.

    - Any therapeutic interventions to include, but not limited to, therapy, assessments, care coordination, team meetings, and treatment planning can occur via telehealth.
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP, if one is required, shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19 as well as any newly identified problem and documented according to the requirements in the CMHRS Provider manual.
- Independent Assessment Certification and Coordination Team (IACCT) Assessments
    - IACCT Assessments may occur via telehealth or telephone communication.
    - IACCT Assessments may be completed by out-of- network providers, but these individuals must be an independent evaluator separate from the residential facility. IACCT Assessments completed by an out-of-network provider must be coordinated with Magellan of Virginia.
- Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care
    - The requirement for service authorization remains in place.
    - Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth. The plan of care should be updated to include any change in service delivery as well as any change in goals, objectives, and strategies, including impacts on the individual due to COVID-19.
    - For members in psychiatric inpatient, facility based crisis stabilization, PRTF and TGH, medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines. Providers who are requesting service authorization for members who are unable to discharge due to barriers related to COVID-19, are asked to answer the following questions when requesting an authorization.

Providers shall submit an additional page with the information when submitting the request online or be prepared to answer the questions during phone reviews.

1. What are the barriers to discharge related to COVID-19?
2. Please describe attempts to overcome these barriers since the last Service Request Authorization was submitted.
3. What are the restrictions and/or limitations for step-down to the identified discharge disposition?
4. What aftercare services are available in their community during this pandemic?
5. What agencies has this individual been referred to?
6. How will the treatment plan and goals be adjusted to sustain current progress and prevent regression?

Answering all these questions when requesting authorization will expedite the review process. The answers to these questions are required each time you are requesting continued stay for a member who has not discharged due to barriers related to COVID-19.

- If an individual currently in a PRTF or TGH requires acute or inpatient medical treatment (non-psychiatric) for more than seven days for PRTF and ten days for TGH, the authorization

will NOT be ended and the individual does not have to be discharged from the PRTF or TGH. For any subsequent admission to a PRTF or TGH, the previous admission shall be extended. The provider shall not bill for the time where the individual is admitted into acute care.
- Providers should refer to guidance from the CDC regarding best practices for facilities.
- If members are in need of quarantine because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the VDH webpage.
- If individuals are in need of quarantine and hospitals are attempting to step them down to a psychiatric unit or facility, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down.
- Service authorization requirements and medical necessity criteria will have to be met for admission into this level of care.

Policy Flexibilities Applicable to Addiction and Recovery Treatment Services (ARTS)

- ASAM 2.1 and 2.5 Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP)
    - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
    - Providers will not be required to discharge members from the service if the provider is billing outpatient services rather than PHP or IOP codes.
    - If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP as detailed in the July 22, 2020 memo titled “Changes to the Service Delivery Hour Requirements for Addiction and Recovery Treatment Services (ARTS) Intensive Outpatient Services (IOPs) Effective August 1, 2020 and Clarification for Partial Hospitalization Services (PHS) Requirements”, providers may bill the most appropriate psychotherapy, assessment, and evaluation codes.
        - During the PHE, if CSACs or CSAC-Supervisees are performing substance use disorder (SUD) counseling within their scope of practice, DMAS will waive the requirement for only licensed practitioners to bill the psychotherapy codes. CSACs and CSAC-Supervisees will be allowed to bill using the most appropriate psychotherapy code based on the amount of time spent performing the service, bill under their licensed supervisor NPI and document the reason for billing the psychotherapy code by the CSAC or CSAC-Supervisee is due to not meeting the minimum time for billing the per diem.
    - The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual’s progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual’s medical record as evidenced by the dated signatures of the Credential Addiction Treatment Professional, LMHP-R, LMHP-RP or LMHP-S.

Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.

- ASAM Levels 3.1 and Above
  - Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified.
  - Therapy, assessments, case management, care coordination, team meetings, and treatment planning can occur via telehealth or telephonic consults.
  - Providers shall maintain appropriate documentation if the plan to provide or continue care deviates from the normal protocol or plan of care.
  - For members in ASAM Level 3.1 and above, medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines. Please see the additional requirements above in section "Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care" for information providers are required to submit to justify a delay in discharge due to COVID-19.
  - Providers should refer to guidance from the CDC regarding best practices for facilities.
  - If members need to be quarantined because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the VDH webpage.
  - If individuals need to be quarantined and hospitals are attempting to step them down to a lower ASAM Level of Care, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down.
  - Service authorization requirements and medical necessity criteria as noted in this memo will have to be met for admission into this level of care.
  - The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID 19 as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the Credential Addiction Treatment Professional, LMHP-R, LMHP-RP or LMHP-S.

Opioid Treatment Programs (OTP) and Preferred Office-Based Opioid Treatment (OBOT) Services

Individuals with Opioid Use Disorder (OUD) may have high-risk co-morbidities such as chronic obstructive pulmonary disease (COPD), cirrhosis, or HIV that may increase the risk of severe disease related to COVID-19. In light of the potential risk of exposure to COVID19, as well as barriers to accessing treatment due to illness, quarantine, and risk of serious illness, we ask providers and staff to exercise clinical judgment and to prioritize the continuation of members' medication for treatment of OUD (MOUD).

In line with the updated National Practice Guidelines issued by the American Society of Addiction Medicine (ASAM), DMAS is instructing providers of medication for opioid use disorder or alcohol use disorder to not delay initiation or continuation of medication due to a member's inability to see medical or behavioral health clinicians face-to-face. DMAS expects that Preferred OBOTs and OTPs remain open and accept new patients interested in MAT initiation during this time. If a Preferred OBOT or OTP is at member capacity for MAT services, the Preferred OBOT or OTP should have procedures in place to connect individuals with care.

DMAS is especially mindful of the mental and emotional duress that may be experienced by Medicaid members as well as potential disruptions in illicit drug supply that may encourage individuals to seek treatment and the importance of initiating MAT during this time. DMAS echoes SAMHSA in the strong recommendation of "the use of telehealth and/or telephonic services to provide evaluation and treatment of patients. These resources can be used for initial evaluations including evaluations for consideration of the use of buprenorphine products to treat opioid use disorder".

(https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mentalsubstance-use-disorders-covid19.pdf)

- OTPs and Preferred OBOT Providers are considered essential medical services. Thus, providers shall be making efforts to ensure current members have access to life saving medications. Providers shall also be making necessary arrangements to serve new members who are in need of initiation of medication for opioid use disorder or alcohol use disorder. The initiation of these medications can be done through telehealth during the PHE.
- DMAS also recognizes that members may not be able to pick up their medications from OTPs during this PHE. Thus, DMAS will allow OTP providers to deliver the medications to the member's location and be reimbursed for this service.
    - For delivery of up to a two week supply of medications: Bill 5 units of H0020 at $8.00/unit (equates to $40.00 or 70 miles round trip applying the federal personal mileage rate of 57.5 cents per mile).
    - For delivery of three weeks or greater supply of medications: Bill 10 units of H0020 at $8.00/unit (equates to $80.00 or 140 miles round trip).
- DMAS is allowing flexibility of the rule defined in the ARTS program manual, which limits the reimbursement of medication administration encounters within OTPs to only those encounters when the member is presenting in-person, daily, to get their medication dose.
    - The OTPs have received approval from the State Opioid Response Authority to administer medication as take-home dosages, up to a 28-day supply, to minimize exposure of COVID-19 to staff and patients.
    - Thus, DMAS is allowing for the reimbursement of the medication encounter for the total number of days' supplied of the take-home medication. This flexibility is critical to minimize face-to-face contact during the emergency.
- DMAS is allowing Preferred OBOTs and OTPs the flexibility during the PHE to review and update the IPOC at least every 90 calendar days instead of every 30 calendar days to alleviate some burden on providers. Providers shall modify the IPOC as the needs and progress of the member changes. An IPOC that is not updated either every 90 calendar days or as the member's needs and progress change shall be considered outdated.

Back-Up Staff

Preferred OBOTs, OTPs, in-network buprenorphine waivered practitioners, and behavioral health clinicians shall be prepared in the case of staff illness, including making arrangements for backup prescribers and behavioral health clinicians. DMAS recommends making these arrangements in advance and ensuring in-network back-up providers are available for each Medicaid MCO or Magellan of Virginia for fee-for-service member. If an in-network provider is not available for a member, providers shall contact MCO or Magellan of Virginia Network Relations staff.

Counseling and Other Requirements

During the PHE, DMAS is allowing the counseling component of Medication Assisted Treatment (MAT) to be provided via telehealth or telephone communication. If a Preferred OBOT or OTP member is unable to participate in counseling services due to COVID-19, DMAS will not penalize the Preferred OBOT or OTP provider for the missed services.

The provider must have emergency procedures in place to address the needs of any member in a psychiatric crisis. The provider should also ensure that the member continues to have access to medications to treat OUD, as well as care coordination activities as appropriate. Preferred OBOT and OTP providers may continue to bill for care coordination that is provided telephonically and in the absence of counseling services, if necessary and appropriate.

Face-to-Face Contact Requirements

Face-to-face contact requirements are waived for care coordinators, counselors, and peer recovery support specialists within Preferred OBOT or OTP. Staff members may use telehealth, including telephonic communication, and should use the same billing codes. Any type of contact with the member shall be documented, including the method of contact (face-to-face, telehealth, telephonic.) This includes obtaining verbal signatures from members in conducting the reviews for IPOCS and ISPs.

Urine Drug Tests

Providers should use clinical judgment when requiring urine drug tests to minimize clinic and member exposure to COVID-19. DMAS will not penalize Preferred OBOTs or OTP's for missed urine drug tests during the PHE. DMAS encourages providers to familiarize themselves with the recent bulletin "Guidance for the use of Urine Drug Testing in Substance Use Disorder (SUD) Treatment" posted September 4, 2020.

Providing MOUD via Telehealth

Under the Ryan Haight Act of 2008, general requirements are that the prescribing practitioner shall have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance (including buprenorphine and buprenorphine/naloxone) for treatment of addiction. However, during the federal PHE, the Drug Enforcement Agency (DEA) has lifted the requirements under the Ryan Haight Act of 2008 for prescribing practitioner to have conducted at least one in-person medical evaluation of the patient before prescribing a controlled substance scheduled II – V, including buprenorphine and buprenorphine/naloxone for treatment of addiction. For as long as the federal HHS designation of a PHE remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The telemedicine communication is conducted by questioning the patient over the telephone or via telemedicine using a real-time, two-way, audio-visual communications device.
- The practitioner is acting in accordance with applicable Federal and State law. Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using

any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy (https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf).

- The initial visit for Buprenorphine prescribing via home as originating site is allowed as long at the DEA requirements are met above.

Buprenorphine (Schedule III) Products and Refills

As noted in the March 19, 2020 memo, Fee-for-Service and Medicaid managed care health plans will:

1. Suspend all drug co-payments for Medicaid, FAMIS and FAMIS Moms members.
2. Cover a maximum of a 90 day supply for all drugs excluding Schedule II drugs. In Virginia, Schedule II drugs include most opioids, amphetamines, methylphenidate, etc. A complete list of Schedule II drugs can be found at: https://law.lis.virginia.gov/vacode/title54.1/chapter34/section54.1-3448/.
3. Suspend refill "too soon" edits for all drugs prescribed for 34 days or less. Drugs dispensed for 90 days will be subject to a 75% refill "too-soon" edit. Patients will only be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).
4. Federal and state law prohibit the early refilling of Schedule II drugs except in the case of an emergency. Pharmacists should refer to Virginia Board of Pharmacy's guidance for emergency fill procedures.

Pharmacists and prescribers must continue to comply with all applicable state and federal laws and regulations related to the prescribing and dispensing of controlled substances. Pharmacists are encouraged to review the Virginia Board of Pharmacy's "Emergency Provisions for Pharmacists during the COVID-19 Declared Emergency" for additional guidance available www.dhp.virginia.gov/Pharmacy.

Naloxone

Providers are advised to write prescriptions for naloxone for members prescribed medications for opioid use disorder, in case of interruptions in community-based distribution. Note that Medicaid also reimburses for Naloxone standing order prescriptions per the Commissioner of the Virginia Department of Health.

Preferred OBOT Prescription Management

During the PHE, DMAS asks Preferred OBOTs to consider giving individuals who are deemed 'clinically stable' longer prescription lengths of buprenorphine containing products, as permitted by the Virginia Board of Pharmacy. 'Clinically stable' should be determined by the prescribing provider's clinical judgment and care team. DMAS encourages providers to consider a minimum two-week supply of buprenorphine-containing products, and telehealth or telephonic follow up when clinically appropriate to lessen an individual's risk of coming into contact with persons who may be

carrying the virus. Providers should review proper prescription storage for the safety and well-being of members.

Sublocade and Vivitrol

If a member is receiving subcutaneous buprenorphine (Sublocade) and cannot attend a clinic, providers can transition the member to sublingual buprenorphine (Suboxone) without additional in-person examinations. Similarly, members receiving intramuscular naltrexone (Vivitrol) may be transitioned to oral naltrexone without an additional examination.

In-Network Buprenorphine Waivered Practitioners

Information contained in this section for medications for opioid use disorder applies to in-network buprenorphine waivered practitioners. Please note that if prescribers are not in-network with DMAS or the Medicaid MCOs, prescriptions for buprenorphine products are not reimbursed at local pharmacies. Also, providers who are not approved as Preferred OBOT providers, are not eligible for care coordination reimbursement.

Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both Frequently Asked Questions (FAQs) and guidance regarding new flexibilities as they are implemented. For additional questions about this memo or other COVID-19 related issues, the agency has created a centralized point of access for submission at http://dmas.virginia.gov/contactforms/#/general. Questions may also be submitted to COVID19@dmas.virginia.gov.

If you have additional questions about the behavioral health specific portions of these memos, you may email EnhancedBH@dmas.virginia.gov or SUD@dmas.virginia.gov.

Telehealth:

During the federal emergency period, current telehealth policies and flexibilities will continue as described in prior Medicaid Memoranda issued on March 19, 2020 (Provider Flexibilities Related to COVID-19) and May 15, 2020 (New Administrative Provider Flexibilities Related to COVID- 19) and most recently on September 30, 2020 (Updates on COVID-19 Continuation and Timelines for Behavioral Health and Addiction and Recovery Treatment Services). DMAS is working with state and federal authorities to develop and transition into a long-term telehealth policy that will be implemented after the emergency period. Information on that policy and transition plan will be provided in a future Medicaid Memorandum.

Fair Hearings/Appeals:

The following appeal flexibilities will be extended until the end of the federal public health emergency on April 20, 2021:

1. An extension for the timeframe to file client appeals. During the emergency, Medicaid/FAMIS applicants and members in DMAS fee-for-service are afforded greater than thirty (30) days from the adverse action to file the appeal and members enrolled in a Medicaid Managed Care Organization ("MCO") are afforded greater than 120 days from the MCO's internal appeal decision to file an appeal with DMAS.

2. Delays in scheduling client appeal hearings and issuing client appeal decisions. CMS concurred that the public health emergency related to COVID-19 warrants the use of the exception described in regulation to delay taking final administrative action, which includes scheduling of fair hearings and issuing fair hearing decisions due to an emergency beyond the state's control. (42 CFR 431.244(f)(4)(i)(B)). DMAS will add the applicable delay for the appeals in process during the period of emergency.
3. Verbal authorization for representation during the appeal. During the public health emergency, the federal government suspended the requirement for written authorization and allows for an appellant to designate a representative through verbal authorization.

The following appeal flexibilities were based exclusively on the authority provided by Governor Northam's Executive Order 51 and will be extended until the end of the Executive Order:

1. Automatically continuing coverage during client appeals when the action involved a denial, reduction, or termination of existing eligibility or services. During the emergency, the coverage is automatically continued by the MCO during the internal appeal and by DMAS during the State Fair Hearing, with no financial impact to the
2. member. When an appeal has been filed, the coverage will continue during the appeal at the previously approved level; any amount over the previously approved level and new requests for services will not be subject to automatic continued coverage and will be reviewed to determine medical necessity.
3. Automatically grant client appeal reschedule requests and schedule a new hearing when the appellant misses a scheduled hearing. During the emergency, the hearings are automatically rescheduled at the appellant's request or if the appellant misses a hearing. DMAS is clarifying in this memo that if the appellant misses more than one hearing, the DMAS Appeals Division will contact the appellant in writing to determine if the appellant still wants the appeal to proceed. Any response to continue the case will be granted. However, if an appellant does not respond to DMAS within 15 days of the letter being sent, the appeal will be closed.
4. Conduct all hearings via telephone. Due to the nature of COVID-19, DMAS has suspended all in-person client appeal hearings and informal fact-finding conferences during the period ofthe Executive Order.
5. Extension of provider appeal timeframes. Using the authority granted in the Executive Order, the provider appeal regulatory deadlines after an appeal is filed are extended for a period equal to the length of the total duration of the emergency, unless specific deadlines are set by the Informal Appeals Agent or Hearing Officer.

The following appeal flexibilities are being ended as of the date of this Memo:

1. A shortened timeframe for MCOs to issue an internal appeal decision in non-expedited client appeals. DMAS previously reduced the timeframe for MCOs to issue an internal appeal decision to fourteen (14) days from receipt of the appeal request in non- expedited cases. DMAS is now restoring this time period back to the traditional 30-day period for the MCO to issue the appeal decision in non-expedited case. The 30-day period applies to any non-expedited client appeals filed with the MCO on and after the date of this memo.
2. Extension of provider appeal timeframes. Using the authority granted in the Executive Order, the provider appeal regulatory deadlines following an appeal being filed were extended. All provider appeals filed with the DMAS Appeals Division on and after the date of this memo will be processed in accordance with the timeframes set forth in DMAS' provider appeal

regulations. This applies to both informal provider appeals and formal provider appeals filed with DMAS on and after the date of this memo.

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PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/

Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee- for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms

Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or Call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	www.aetnabetterhealth.com/Virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-800-901-0020
Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166
United Healthcare	www.Uhccommunityplan.com/VA and www.myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711),

authorizations for fee-for-service members.	call: 1-800-424-4046

Provider HELPLINE Monday– Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	aetnabetterhealth.com/virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-800-901-0020
Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166
United Healthcare	Uhccommunityplan.com/VA and myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711)