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https://dmas.virginia.gov
MEDICAID MEMO

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Developmental Disabilities (DD) and Commonwealth Coordinated Care (CCC)Plus Waivers: Provider Flexibilities Related to COVID-19

This memo is part of a series that sets out the Agency's guidance on the flexibilities available to providers in light of the public health emergency (PHE) presented by the COVID-19 virus. The flexibilities in this memo include specific items related to Home and Community-Based Services (HCBS) Waivers, including the DD Waivers and the CCC Plus Waiver. These flexibilities are relevant to the delivery of covered services for COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact and were included in earlier DMAS Medicaid memos dated March 19, 2020, April 22, 2020, May 15, 2020, June 26, 2020, August 11, 2020 and January 14, 2021.

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.

Appendix K Extension

DMAS has requested authority to extend the expiration date of the current 1915(c) Waiver Appendix K amendment to six months after the conclusion of the federally recognized public health emergency. This is the maximum allowable time under federal law. This extension allows DMAS to extend all flexibilities until the end of the Appendix K authority. Keeping the federal authority of Appendix K clears the way of any federal barriers for the State to take action more expediently in the event of COVID-19 resurgences in the Commonwealth. However, while DMAS maintains federal approval to extend the flexibilities, it is important to note that not all flexibilities will - remain in effect through the expiration date of Appendix K. The purpose of this memo is to outline the planned expiration of certain flexibilities through Appendix K.

The health, safety, and welfare of our members is very important to all of us. When the flexibilities were established, there was little information known about how to adequately protect our members from COVID-19 transmission. March 12th will mark one year since the flexibilities became effective. This means that some of our most vulnerable members have not had an in-person visit from a provider for at least one year. In order to ensure the health and welfare of members is being monitored and addressed, it is imperative that some of the flexibilities be ended or changed.

Flexibilities that ended on July 31, 2020

Retainer payments were made available to providers of Adult Day Health Care, Group Day Services, Community Engagement, and Community Coaching. Retainer payments covered from the date of the emergency on March 12, 2020 through July 31, 2020 for providers with active authorizations during that period. The ability to bill for retainer payments ended on December 31, 2020.

Flexibilities that will end effective April 30, 2021

Personal care, respite, and companion providers in the agency or consumer-directed program, who are providing services to individuals over the age of 18, will no longer be permitted to work for up to sixty (60) days, while criminal background registries are checked. Providers shall comply with the background check requirements consistent with Virginia Code § 32.1-162.9:1.

Flexibilities that will change effective May 1, 2021

Beginning, May 1, 2021, in-person visits will be required as outlined below. In the event the member refuses the in-person visit, the provider shall document, in the member's record, the reason the face-to-face visit could not be made and a telehealth visit should be conducted. Providers shall use social distancing protocols and proper face masks when conducting the visit. Please visit the CDC website (https://www.cdc.gov/coronavirus/2019-ncov/index.html and https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html) for more information on protecting yourself and others.

1. Personal care, respite, and companion services- agency-directed and consumer-directed. For members that have not had an in-person visit on or after 3/12/2020, the next required agency supervisory or services facilitator reassessment/routine visit should be done in person. In-person visits shall be required every six months for the duration of the PHE. Telehealth visits may be conducted for visits that occur in between the six month in-person visits.
2. Newly enrolled members in the waiver or waiver service. In-person visits will be required for anyone newly enrolled in the waiver or in a waiver service with effective dates of May 1, 2021 or after. This will ensure thorough assessments and adequate plans of care are established in collaboration with the member. In-person visits shall be required every six months for the duration of the PHE. Telehealth visits may be conducted for visits that occur in between the six month in-person visits.
3. Any member with a significant change requesting an increase in support due to changes in medical condition and/or changes in natural supports.
4. DD or Intellectual Disability (ID) Waiver case management face-to-face visits for individuals enrolled in one of the DD waivers shall be conducted in person. This applies to targeted case management including visits for completion of the SIS, VIDES, annual plan meetings, and case management visits. The SIS, VIDES and annual plan meetings should be held in an appropriate setting allowing for social distancing and other precautions; case management visits shall be coordinated with the individual, family and/or residence to ensure that all precautions can be maintained and protocols followed.

Flexibilities that will end effective August 1, 2021

DMAS will re-evaluate the need to continue these flexibilities prior to the end date.

1. Allow legally responsible individuals (parents of children under age 18 and spouses) to provide

personal care/personal assistance services for reimbursement. Fiscal/employer agents will be providing additional information about the ending of this flexibility.
2. Allow Community Engagement (CE)/Community Coaching (CC) to be provided through telephonic/video-conferencing for individuals who have the technological resources and ability to participate with remote CE/CC staff via virtual platforms (e.g., ZOOM, UberConference, etc.) in order to build computer skills to connect them with other community members.
3. Allow In-home Support services to be delivered via an electronic method or telehealth (i.e., telephonic/video-conferencing) of service delivery.
4. Allow Group Day Services to be provided through video conferencing for individuals who have the technological resources and ability to participate with remote Group Day staff via virtual platforms (e.g., ZOOM, UberConference, etc.) in order to build skills to connect them with other community members and maintain current independent living skills. These services will not be allowed to be provided telephonically.

Flexibilities that will continue until further notice in order to maximize provider staffing and access to care:

1. Personal care, respite, and companion aides hired by an agency shall be permitted to provide services prior to receiving the standard 40-hour training. Providers will be required to ensure that aides are proficient in the skills needed to care for participants prior to providing care. Aides must receive the forty (40) hour training within ninety (90) days of starting care.
2. CCC Plus Waiver members who receive less than one service per month will not be discharged from a HCBS waiver. Waiver individuals shall receive monthly monitoring when services are furnished on a less than monthly basis. Monthly monitoring may be in the form of telehealth visits including phone calls. As clarified in the DMAS Medicaid Memo, dated May 15, 2020, monthly monitoring shall be performed by the CCC Plus managed care plan, or DMAS for fee-for-service (FFS), when the member does not receive a waiver service monthly.
3. Residential providers are permitted 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.
4. Allow Therapeutic Consultation activities that do not require direct intervention by the behaviorist to be conducted through telephonic/video-conferencing methods.
5. Allow Group Day Services to continue to be provided by and reimbursed to the authorized Day Support provider when provided in residential settings.
6. Electronic signatures will be accepted for visits that are conducted through telehealth in accordance with the previously established requirements.
7. For services facilitation providers, the consumer (Individual) Training visit (S5109) and Services facilitation training (S5116) may be conducted using telehealth methods.

ADDITIONAL INFORMATION ON THE MEDICAID WAIVERS:

DBHDS website:

http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community

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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.	**Visit**: www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	**Call**: 1-800-884-9730, or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	**Visit**: 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	**Visit**: http://www.dmas.virginia.gov/#/med4
CCC Plus	**Visit**: http://www.dmas.virginia.gov/#/cccplus
PACE	**Visit**: 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.	**Visit**: http://www.magellanhealth.com/Provider For credentialing and behavioral health service information: **Visit**: www.magellanofvirginia.com **Email**: VAProviderQuestions@MagellanHealth.com **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.	**Call**: 1-804-786-6273, or 1-800-552-8627
Aetna Better Health of Virginia	**Visit**: www.aetnabetterhealth.com/virginia **Call**: 1-800-279-1878
Anthem HealthKeepers Plus	**Visit**: www.anthem.com/vamedicaid, or **Call**: 1-800-901-0020
Magellan Complete Care of Virginia	**Visit**: www.MCCofVA.com **Call**: 1-800-424-4518 (TTY 711), or 1-800-643-2273
Optima Family Care	**Call**: 1-800-881-2166

United Healthcare	**Visit**: www.uhccommunityplan.com/VA, or www.myuhc.com/communityplan **Call**: 1-844-752-9434, TTY 711
Virginia Premier	**Call**: 1-800-727-7536 (TTY: 711)