Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

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COVID-19 Flexibility Continuations Until 1/20/2021

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

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 January 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. Normal DMAS policies and procedures are in effect for any flexibilities not discussed in this memo.

Nursing Facilities and Medicaid Long Term Services and Supports Screenings (LTSS) for Community- Based Services:

Per provision 313.LLLLL in the 2020 Appropriations Act, the additional $20 per diem payment for nursing homes and specialized care facilities shall continue for the period of the Governor's Declaration of a State of Emergency in Executive Order 51.

DMAS will continue to extend the following flexibilities until January 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. Such screenings shall be conducted either through telehealth or telephone services. Consent for performing the screening and authorization to

distribute the screening to providers may be confirmed through verbal consent and witnessed by two members of the entity legally authorized to perform the screening.
2. Extend minimum data set authorizations for nursing facility and skilled nursing facility (SNF) residents.
3. Waive 42 CFR 483.20(k) allowing nursing homes to admit new residents who have not reached Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness or intellectual disability should be referred promptly by the nursing home to state PASRR program for Level 2 Resident Review.
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 SNF and 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 for 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. 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.

Home Health and Hospice:

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

1. Waive the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two (2) weeks to evaluate if home health 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.
2. Suspend the 2-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 required to contact the home health aide or the member/caregiver to set up the supervisory visit.
3. 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.
4. 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:

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

1. DMAS will allow 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 ATP.
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 durable medical equipment via telehealth.
    1. 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.
3. 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.
4. 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.

5. 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 public health emergency. 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.
6. 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.
    1. 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 public health emergency declaration (January 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):

DMAS recently issued a memorandum on September 30, 2020 summarizing 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 will be extended until January 20, 2021, or longer if the federal government extends

the PHE further. This memo is located at: https://www.dmas.virginia.gov/files/links/5555/Behavioral%20Health%20and%20ARTS%20COVID-19%20Policies%20Update%20(9.30.20).pdf.

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 January 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. A shortened timeframe for MCOs to issue an internal appeal decision in non-expedited client appeals. During the emergency, DMAS MCOs are required to issue an internal appeal decision within fourteen (14) days of receipt of the appeal request in non-expedited cases.
3. 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.
4. 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 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.
2. 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.
3. 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 of the Executive Order.
4. 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.

<u>Eligibility and Enrollment:</u>

With the announcement of the extension of the federal Public Health Emergency (PHE), continuity of coverage must remain until January 31, 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 and children under age 19. Additionally, the continuity of coverage requirements do not apply for coverage in a separate CHIP program. In Virginia, this includes 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 Marketplace coverage.

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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)