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MEDICAID MEMO

Last Updated: 03/09/2022

New 1135 Waiver and Administrative Provider Flexibilities Related to COVID-19.

This memo is the sixth in a series that sets out DMAS's guidance on the flexibilities available to providers in light of the public health emergency presented by the COVID-19 virus. This memo contains changes for which DMAS sought and received federal approval effective April 14, 2020, through an 1135 Waiver. This memo also contains clarifications on certain administrative procedures for the COVID-19 virus. Under section 1135 of the Social Security Act, Virginia has requested the Centers for Medicare and Medicaid Services (CMS) to waive or modify certain Medicaid and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of Medicaid members during the State of Emergency. The flexibilities in this memo include changes that affect both fee-for-service (FFS) and managed care organization (MCO) models of care and the Program of All-inclusive Care for the Elderly (PACE). These flexibilities are relevant to the delivery of covered services related to COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact.

Please note that the policy changes set out in this memo are in effect during the public crisis, as set out in the Governor's Emergency Declaration issued on March 12, 2020. DMAS provider flexibilities released in earlier memos (March 19 and 27, 2020) as a result of COVID-19 virus are still in effect. This is a rapidly emerging situation and additional changes are forthcoming. 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 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 COVID-19@dmas.virginia.gov.

Out-of-State Providers

- DMAS is waiving requirements that physicians and other health care (including behavioral healthcare) professionals be licensed in Virginia in order to provide services to Virginia residents, so long as they have equivalent licensure in another state. Providers will need to follow the requirements set forth through the appropriate regulatory board at the Department of Health Professions to determine what requirements and processes apply.

- DMAS is allowing Medicaid enrollment of out-of-state licensed providers. (The Department of Health Professions, the Department of Behavioral Health and Developmental Services, or the Department of Health, as the licensing agencies for various provider types, may have additional requirements that must be met before out-of-state providers may provide services in Virginia.)

Provider Screening and Enrollment Changes for FFS and MCOs

- Certain requirements are being waived for Medicaid enrollment and screening purposes. The changes listed below do not affect provider and licensing requirements established by the Department of Health Professions, the Department of Health, or the Department of Behavioral Health and Developmental Services – those requirements remain in place. MCOs will adhere to any changes that will not directly change their current contractual obligations with DMAS.DMAS is waiving provider application fees.
- DMAS is waiving criminal background checks for providers of adult services for individuals over the age of 18.
- DMAS is waiving site visits conducted prior to enrolling a provider.
- DMAS is postponing deadlines for revalidation of providers.
- DMAS is waiving conditions of participation or conditions for coverage for existing providers for facilities for providing services in alternative settings, including using an unlicensed facility, if the provider's licensed facility has been evacuated.

Clarifications and Changes Related to the Medicaid Long-Term Services and Supports (LTSS) Screening

LTSS Screening for Home and Community-Based Services (HCBS)

Community Based Teams (CBTs) and Hospital Based Teams (HBTs) should continue to evaluate individuals seeking enrollment in Medicaid long-term services and supports. This includes the Commonwealth Coordinated Care (CCC) Plus Waiver or Program of All-inclusive Care for the Elderly (PACE). This screening determines functional and medical/nursing needs and to determine if the individual is in need of, or at risk of, institutional placement/nursing facility care within 30 days.

CBTs must suspend face-to-face screenings and shall not enter facilities serving older adults, such as assisted living and nursing facilities. All LTSS screenings are to be conducted using telehealth methods either through the secure app called "Doxy.me"

operated through the Virginia Department of Health (VDH), or through the use of telephone interviews. All available medical/health records should also be reviewed prior to finalization and submission of the screening into the electronic screening portal. Community screenings must be completed within 30 days of the initial request. Should there be instances of exceeding this requirement due to the effects of COVID-19 on the locality or CBT staffing pattern, teams should document this for the record and apprise the VDH LTSS Screening Manager of the situation.

CBTs may obtain verbal consent from the individual or authorized representative for the DMAS-97 Individual Choice form when two LTSS screeners/individuals verify the response. Both witnesses should sign the DMAS-97 indicating the individual's verbal choice, and this form should be maintained with the individual's case record.

The Medicaid LTSS Authorization form DMAS-96 still must be signed/attested to by the CBT LTSS Screeners and physician (or physician's assistant or nurse practitioner). All LTSS Screenings must be successfully processed in the DMAS electronic screening portal known as ePAS.

LTSS Screening for Nursing Facilities

For individuals requesting and needing nursing facility services (including skilled, rehab, or custodial care) directly after discharge from a hospital, the requirement for a Medicaid LTSS Screening is suspended during the COVID 19 public health emergency. For admissions occurring after March 12, 2020, nursing facilities do not need to obtain Medicaid LTSS Screening packages that would normally be required by 12VAC30-60-308, and may admit individuals without the Medicaid LTSS screening package. The individual may be admitted directly to the nursing facility without a LTSS Screening. Nursing facilities must follow the directions below regarding the screening, evaluation and determination for specialized services for individuals who potentially have mental illness, intellectual disability or a related condition, and assure completion resident reviews. This process is known as Pre-Admission Screening and Resident Review (PASRR).

The same requirements that apply to the DMAS 97 Individual Choice form for HCBS screenings also apply in nursing facilities: CBTs and HBTs may obtain verbal consent of the individual or authorized representative for the DMAS-97 when two LTSS screeners/individuals verify the response. Both witnesses should sign the DMAS-97 to indicate the individual's verbal choice, and this form should be maintained with the individual's case record.

For those individuals choosing nursing facility care, the original DMAS-97 should be forwarded to the nursing facility and the hospital should retain a copy.

Entering the Level of Care

The Medicaid Portal's Long-Term Care tab, also referred as the Automated Enrollment and Disenrollment (AE and D) portal, will not validate whether a completed LTSS Screening has occurred for nursing facility admissions until this public health emergency has subsided. For individuals admitted after March 12, 2020 without a LTSS Screening, and for whom no special circumstance exists, nursing facilities and health plans should check "Yes" to the question "Approved Pre-Admission Screening." The admission date included on the form will verify that this admission occurred during the COVID-19 emergency. For all admissions covered by a special circumstance, please continue to check "No" to the "Approved Pre-Admission Screening" question but also check the Special Circumstance that applies.

Nursing Facilities and Preadmission Screening and Resident Review (PASRR)

DMAS is temporarily suspending PASRR Level II evaluations for 30 days after an individual's admission. During the declared COVID-19 public health emergency, all admissions to nursing facilities may be treated as exempted hospital discharges under 42 CFR 483.106. If the individual remains in a nursing facility after 30 days, a resident review shall be conducted as soon as reasonably possible. Nursing facilities should follow the processes for resident review, and notify Ascend, A Maximus Company, for scheduling evaluations related to mental illness, intellectual disability or related conditions.

Ascend, A Maximus Company

Phone: 877-431-1388, Extension 3205

Fax: 877-431-9568

Website: www.ascendami.com

Evaluators for PASRR Level II and resident reviews are permitted to conduct evaluations telephonically or via other telehealth options.

Nursing facilities are urged to complete a PASRR Level I at the time of nursing facility admission in order to facilitate tracking individuals who will require resident reviews. Resident reviews should not be delayed, and should be conducted as soon as possible after the first 30 days of admission.

Minimum Data Set (MDS)

The Minimum Data Set (MDS) is required for both Medicare and Medicaid nursing facilities (NF) residents. The MDS is utilized both for care planning and determining the Medicaid Resource Utilization Group (RUG) for claim pricing. Virginia is following the Medicare waiver of 42 CFR 483.20 to provide relief to skilled nursing facilities (SNFs) on the timeframe requirements for MDS assessments and transmissions. This guidance is provided for Medicaid members and may be adjusted to comport with guidance that CMS may issue pertaining to Medicare residents.

Nursing facilities should continue to complete MDS assessments for new admissions. This assessment is necessary for appropriate care planning and to establish the RUG for Medicaid billing. These assessments should be completed within 30 days (rather than 14 days) of admission. For residents transitioning from Medicare covered SNF care to Medicaid covered NF care, the NF may use the Medicaid RUG from an Omnibus Budget Reconciliation Act (OBRA) assessment within 30 days of transition. Otherwise, the NF must complete an admission assessment. However, DMAS will waive the requirement for quarterly and comprehensive assessments and significant change assessments if the clinical staff is unable to submit them timely. For Medicaid billing purposes, the provider may continue to bill the RUG from the most recent assessment. DMAS encourages NFs to complete the MDS as soon as possible after a significant change as it both informs care planning and establishes the appropriate Medicaid RUG for billing. A RUG for a significant change assessment can be billed back to the significant change as long as the assessment is within 30 days (rather than 14 days) of the significant change assessment. Nursing facilities should continue to submit the correct Assessment Reference Date (ARD) associated with the assessment that generated the RUG submitted on the claim, even though the ARD will not be taken into account during claim processing. All completed assessments should be transmitted to CMS via the Quality Improvement and Evaluation System – Assessment Submission and Processing (QIES-ASAP) application as soon as possible.

This waiver will last through the end of the emergency declaration. Nursing facilities have until the end of the following quarter to reset the quarterly assessment schedule by completing assessments on a staggered based to avoid quarterly assessments due at the same time.

Nurse Aides in Nursing Facilities - Temporarily suspending the four-month limitation in 42 C.F.R. §483.35(d) (except for 42 C.F.R. §483.35(d)(1)(i)) for individuals working in nursing facilities as a nurse aide on a full-time basis.

Skilled nursing facilities and nursing facilities may temporarily employ individuals, who are not certified nurse aides, to perform the duties of a nurse aide for more than four months, on a full-time basis. These facilities still must comply with 42 C.F.R § 483.35(c) by ensuring that nurse aides are able to demonstrate competency in the provision of nursing and nursing related services and skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care.

Hospice

Supervision Visits

Hospice agencies may temporarily suspend the face-to-face supervisory visits performed by a registered nurse. In lieu of a face-to-face supervisory visit, the registered nurse may contact the individual by telephone or via video communication. The nurse should consider contacting the home health aide or the member/caregiver to schedule the supervisory visit. If the nurse performing the supervisory visit is unable to perform the visit because a telehealth option was not available, the supervisory visit can be delayed until arrangements can be made to conduct the visit by telephonic or video means. If a supervisory visit must be delayed, the steps taken in an attempt to perform the visit must be documented in the individual's record.

Home Health Services

Home health agencies may perform certifications, initial assessments, and determines 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.

Home health agencies may temporarily suspend the two-week face-to-face supervisory visits for nurse aides that are done by a registered nurse or licensed therapist. 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 should consider contacting the home health aide or the member/caregiver to set up the supervisory visit. If the nurse performing the supervisory visit is unable to perform the visit because a telehealth option was not available, the supervisory visit can be delayed until arrangements can be made to conduct the visit by telephone or via video communication. If a supervisory visit must be delayed, the steps taken in an attempt to perform the visit must be documented in the individual's record.

Plans of Care and Certifying/Recertifying Patient Eligibility: DMAS will temporarily allow the following, in coordination with the CMS waiver, regarding to the requirements at §§ 409.43 and 424.22 in order to allow a patient to be under the care of a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1861(aa) (5)) who is working in accordance with State law, or a physician assistant (as defined in section 1861(aa)(5)) who is working in accordance with State law, and for such physician/practitioner: (1) order home health services; (2) establish and periodically review a plan of care for home health services (e.g., sign the plan of care), (3) certify and recertify that the patient is eligible for Medicare home health services.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly is a federal program operated by CMS in cooperation with state administering agencies to assure compliance with federal regulations at 42 CFR 460.2 through 210. CMS has issued flexibility and guidance for PACE providers during this COVID-19 crisis. DMAS is Virginia's state administering agency and is offering the following clarifications to aid PACE programs with continuing their care during this emergency time.

PACE sites may use remote technology and telehealth options (including telephone communication) as appropriate, to review or gather member information that would normally be provided as a face-to-face service. These services include: enrollment materials, enrollment consent, telehealth consent, participant assessments (initial, semi-annual, annual, and unscheduled), care planning (interdisciplinary team meetings), daily participant checks, therapy appointments, physician consults, pharmacy renewals, and monitoring to ensure all Medicare and Medicaid services are being provided. The PACE patient liability due date has not changed.

PACE sites must document in the member's records the member's verbal consent, authorization, and confirmation of participation in any or all of the above listed activities. The PACE sites shall obtain written signatures within 45 days after the end of the emergency. It is the PACE program's responsibility to include in their documentation these allowances in order to assure clarity for both the CMS Audit and the DMAS Quality Management Reviews (QMR).

All DMAS QMR reviews will be desk reviews only. All needed materials for the review will be requested from the provider at least 30 days prior to the review. If records can be accessed remotely, remote access may be provided to the QMR reviewer in place of paper or electronic submissions.

All face-to-face reviews during the state of emergency are waived. The use of telephonic and telehealth are acceptable means of completing the annual level of care (LOC) reviews due during the emergency period. Any PACE individual currently in the deemed or waived category will not be required to have an annual review. Initial assessments will continue to need to be submitted in LOCERI System as part of admissions documentation.

DMAS has implemented a weekly conference call through the end of the COVID-19 crisis for PACE providers. These calls provide an important opportunity for further clarification and communication of concerns with DMAS. CMS will provide PACE sites with notification when alternate processes should be discontinued. (To request information about the topics discussed during these calls, please fill out the form at: http://dmas.virginia.gov/contactforms/#/general)

Durable Medical Equipment

- 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.
- 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.

- 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.
- 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.
- DMAS will allow temporary coverage for short-term oxygen use for acute conditions.
    - 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.
    - 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.

Certificate of Medical Necessity (CMN)-

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.

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.

- 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.
- 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.
- 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.

- For new orders, after the end of the state of emergency, a valid CMN will be required for all DME and Supplies.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

DMAS is allowing flexibility for FQHCs and RHCs providers to bill for their Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services from alternative physical settings, such as a mobile clinic or temporary location. This will allow flexibility in site of clinics to promote appropriate infection control.

Pharmacy

DMAS is waiving 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. Instead of patients signing, pharmacists writing "COVID-19," "COVID," or substantially similar language shall be equivalent to receiving a signature.

Transportation

DMAS will permit providers that are located out of state to provide care to Virginia's Medicaid enrollee, in line with the provider enrollment requirements highlighted above.

Fair Hearings and Appeals

Client Appeals

DMAS previously noted that it was seeking federal authority to extend the timeframe to file client appeals during the period of emergency. The federal government has authorized DMAS to extend the deadline to request a State Fair Hearing. If an appeal had a filing deadline during the period of emergency or an adverse action was issued during the period of emergency, and the individual did not file the appeal within the normal deadline, DMAS will not request good cause and the appeal will be processed as if it was timely received.

Medicaid members who are enrolled in a Managed Care Organization ("MCO") must

continue to exhaust the MCO's internal appeal process before appealing to DMAS. However, the federal government has authorized DMAS to reduce the time period for the MCO to issue an internal appeal decision. DMAS is exercising this authority during the emergency by requiring the MCO to issue the internal appeal decision within 14 calendar days of receipt of the appeal request. If the MCO's decision is not issued within the 14-day period, the appeal is deemed exhausted and the enrollee can appeal to DMAS.

Both federal and state regulations afford a right to representation in the appeal as long as there is written authorization by the beneficiary, applicant, guardian, or power of attorney. To the extent possible, appeal requests should include the beneficiary's or applicant's written authorization for the representative to pursue the appeal or the guardianship/power of attorney paperwork. If the authorization is not submitted with the appeal request, DMAS will request that information. In instances where written authorization is not possible, DMAS will accept appropriate verbal authorization. If neither written nor verbal authorization is received, DMAS will proceed with the appeal, but only by communicating with the beneficiary or applicant about the appeal.

Provider Appeals

As noted in the Medicaid Memo issued March 19, 2020, providers affected by the COVID-19 emergency may request an extension to the deadline to file an informal or formal appeal. The request for the extension can be submitted prior to filing the appeal or in the appeal request. Additionally, DMAS has extended deadlines after an appeal has been filed for an additional time period equal to the total number of days of the emergency. This will be calculated by adding the total number of days that the emergency was in effect to the applicable deadline. The Informal Appeals Agent or formal appeal Hearing Officer can set specific earlier deadlines if warranted under the circumstances of the appeal.

Eligibility and Enrollment

Enrollment Closures

For the duration of this health emergency and in compliance with H.R. 6201 "Families First Coronavirus Response Act", no Medical Assistance cases will be closed for any reason including excess income.

- All cancellations of eligibility with closure dates of March 31, 2020 or later, will be reinstated through the end of the emergency.

- No action will be taken that will result in a reduction of coverage (movement of full-coverage to limited-coverage benefits)
- All reductions in coverage with effective dates of March 31, 2020 or later will be reopened to full-coverage through the end of the emergency.
- The only exceptions to enrollment closures will be in the event of death, if an individual reports a permanent move from the state of Virginia, or if an individual requests case closure.

Eligibility Determinations

- Self-attestation by Medicaid applicants of medical expenses for the purposes of meeting a medically needy spenddown will be permitted through the end of the emergency as permitted under 42 CFR § 435.945(a) and 42 CFR § 435.952(c)(3).
- In compliance with section 2104(h) of the CARES Act, any payments of the $600.00 weekly Pandemic Unemployment Compensation will not be counted in determining eligibility for Medicaid or CHIP. This disregard does not apply to payments received based on regular unemployment benefits.
- Section 2201 of the CARES Act allows for a tax credit for 2020 individuals, called "Recovery Rebates" (up to $1,200 for indviduals/$2,400 per couple and $500/per qualifying child). In accordance with section 2201 of the CARES Act and 26 U.S.C. § 6409, this income is not counted in determining eligibility for Medicaid or CHIP. Additionally, this payment will be excluded from countable resources for 12 months from the date that the payment is received.

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	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)