



Department of Medical Assistance Services
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<http://www.dmas.virginia.gov>

MEDICAID MEMO

TO: All Providers Participating in the Virginia Medicaid and FAMIS Programs

FROM: Karen Kimsey, Director
Department of Medical Assistance Services (DMAS)

DATE: 4/22/2020

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

This memo is one in a series that sets out the Agency's guidance on the flexibilities available to providers in light of the public health emergency 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.

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. This is a rapidly emerging situation and additional changes will be forthcoming. Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both FAQ's 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>.

Any flexibilities listed in the March 19, 2020 Medicaid Memo are still in effect during this current state of emergency unless explicitly stated otherwise.

Updates for all HCBS Waivers

The following guidance is pertinent to the state's current HCBS waivers. Unless otherwise noted, these changes are effective March 12, 2020.

- Waiver individuals who receive fewer 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. Monthly monitoring shall be performed by the CCC plus waiver provider including the personal care agency, services facilitator, or adult day health center for those enrolled in the waiver. Monthly monitoring for those enrolled in a DD waiver shall be conducted by the support coordinator.

- Effective April 20, 2020, legally responsible individuals (parents of children under age 18 and spouses) shall be permitted to provide personal care/personal assistance services and be paid during the emergency period. Any legally responsible individual who is a paid aide or attendant for personal care/personal assistance services shall meet all the same requirements as other aides or attendants. Respite requirements remain unchanged; there must be an unpaid primary caregiver to be eligible to receive respite services. For consumer-directed services, the legally responsible individual cannot be both the paid provider and the Employer of Record (EOR). Legally responsible individuals who are currently serving as the participant's back-up plan will not be required to identify a new back-up plan while serving as the paid attendant.
- Effective April 20, 2020, personal care, respite, and companion care agency providers may permit aides to provide services prior to receiving the standard 40- hour training requirement. The provider must ensure that the aide is competent in performing the tasks required in the plan of care prior to the aide delivering services in the home. This should be documented in the employee's personnel file. Providers may utilize online training to meet aide training requirements. Aides must receive the 40- hour training within 90 days of starting care.
- For services facilitation providers, the Consumer (Individual) Training (S5109) may be conducted using telehealth methods.
- Face-to-face visit requirements with members are now waived for initial visits and transfers for personal care, respite, and companion services. Face-to-face visits shall be replaced with telehealth methods of communication including phone calls and video conferencing. Documentation of visits conducted through telehealth must meet the standards required for face-to-face visits. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record and on documentation submitted to the appropriate service authorization entity. Existing face-to-face visit requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of the provider. This applies to both agency-directed and consumer-directed service. This is a change from the March 19, 2020 previous Medicaid Memo and is effective March 31, 2020.

DD Waivers

- **Correction from March 19, 2020 Medicaid Memo:** For retroactive service authorizations, services may be authorized for up to **10 business** (vs. calendar) days after the requested start date for the duration of the emergency.
- If a new DD waiver service or additional hours of an existing DD waiver service are being requested in lieu of a DD waiver service that cannot be delivered temporarily due to the COVID-19 crisis, the new or additional hours of an existing service must be requested through the usual service authorization process. However, the service for which the new

service/additional hours is substituting may be left open and unchanged in WaMS. The new/additional hours of service being requested will be approved for no more than three months; must include the following note with the request: "THIS SERVICE IS BEING AUTHORIZED IN LIEU OF xxxx DUE TO THE COVID-19 CRISIS. [Name of new service/service being requested for increase] AND [Name of service for which this is substituted] WILL NOT BE BILLED DURING THE SAME HOURS." If, after the three-month authorization of the new/additional hours of service, the crisis still warrants the delivery of this service in lieu of the previously authorized service, another request, similar to the first, must be submitted.

- Regarding quarterly reporting requirements for Group Day, Community Engagement, Community Coaching, Group Supported Employment and Individual Supported Employment where programs are temporarily **closed** (*i.e.*, staff are not working and individuals are not being served):
 - DMAS will not expect the provider to do any quarterly reports. Once the state of emergency is over and the provider once again has staff working, staff shall put a note in each person's record that says, "No services rendered from XX/XX/XXXX – XX/XX/XXXX due to COVID."
 - The provider shall then summarize in quarterly report fashion whatever happened in the partial quarter before closing. The next quarterly reporting period for each individual will then pick up from the date when the provider reopens and will run through that individual's normal end of quarter date according to ISP date.
 - Auditors will not penalize the provider for the summary of pre-COVID-19 activities/progress being done late and will not expect to see anything in the interim between closure and re-opening.
- **It should be noted that competencies are not portable across agencies** and any staff moving to a new employer would be followed by the completion of competencies in the new location. The orientation training, testing, and assurances remain portable from one agency to the next.
- 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.

CCC Plus Waiver

- **Correction from March 19, 2020 Medicaid Memo:** Providers shall document in their records the member's verbal consent, authorization, and confirmation of participation. The provider **shall not** be required to obtain written signatures after the end of the emergency.
- All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are waived. This waiving of face-to-face requirement is for both past due and currently due level of care evaluations. For CCC Plus Waiver members who have had a face-to-face health risk assessment (initial or reassessment) from October 1, 2019 through March 12,

2020, the information from this assessment may be used to submit LOCERI data in lieu of the face-to-face meeting to complete and to submit the annual level of care evaluation. The due dates for re-evaluations for level of care have been extended from 12 months to 18 months.

Medicaid Expansion Eligibility Verification

Medicaid coverage for the new expansion adult group began January 1, 2019. Providers may use the Virginia Medicaid Web Portal and the Medicall audio response systems, as shown in the table below, to verify Medicaid eligibility and managed care enrollment, including for the new adult group. In the Virginia Medicaid Web Portal, individuals eligible in the Medicaid expansion covered group are shown as “MEDICAID EXP.” If the individual is enrolled in managed care, the “MEDICAID EXP” segment will be shown as well as the “MED4” (Medallion 4.0) or “CCCP” (CCC Plus) managed care enrollment segment. Eligibility and managed care enrollment information is also available through the DMAS Medicall eligibility verification system. Additional Medicaid expansion resources for providers are available on the DMAS Medicaid Expansion webpage at: <http://www.dmas.virginia.gov/#/medex>.

<u>PROVIDER CONTACT INFORMATION & RESOURCES</u>	
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

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