Department of Medical Assistance Services
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Richmond, Virginia 23219

http://www.dmas.virginia.gov

# MEDICAID MEMO

**TO:** All Providers of Home and Community Based Services Waivers (HCBS) and Early Periodic Screening, and Diagnosis and Treatment (EPSDT) services participating in Virginia Medical Assistance Programs and Medicaid Managed Care Organizations (MCOs)

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

**DATE:** 6/26/2020

**SUBJECT:** Home and Community Based Services Waivers (HCBS) COVID-19 Policy Continuation and Timeline

This memo sets out guidance from the Department of Medical Assistance Services (DMAS) on the regulatory 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 Developmental Disabilities (DD) Waivers and the Commonwealth Coordinated Care Plus (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, and May 15, 2020.

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.

**Continuation of HCBS 1915(c) Waiver Flexibilities**

The duration of the HCBS 1915(c) Waiver flexibilities that were set forth during this emergency in an appendix to the 1915(c) Waiver, Appendix K are currently effective through June 30, 2020. However, DMAS received approval from the Centers for Medicare and Medicaid Services (CMS) to extend the HCBS flexibilities for the full allowable time under federal law (January 26, 2021). This extension allows DMAS to extend all flexibilities past June 30, 2020, and some until the end of the Appendix K authority. Keeping the federal authority 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, any state regulation or program policy waived to exercise these federally available flexibilities is tied with and authorized under Executive Order 51. The purpose of this memo is to outline the planned expiration date changes of the HCBS 1915(c) Waiver flexibilities. For flexibilities that are scheduled to end prior to the end of the Appendix K, DMAS will re-evaluate the need to continue these flexibilities prior to the end date.

Flexibilities that will continue until January 26, 2021

DMAS will maintain the following flexibilities through January 26, 2021 in order to maintain provider staffing, maximize access to care, and minimize viral spread through community contact.

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. Personal care, respite, and companion providers in the agency- or consumer-directed program, who are providing services to individuals over the age of 18, may work for up to sixty (60) days, as opposed to the current 30-day limit in Virginia Code § 32.1-162.9:1, while criminal background registries are checked. Consumer-directed Employers of Record (EORs) must ensure that the attendant is adequately supervised while the criminal background registry check is processed. Agency providers must adhere to current reference check requirements and ensure that adequate training has occurred prior to the aide providing the services in the home. Agency providers shall conduct weekly supervisory visits through telehealth methods when the aide works prior to receiving criminal background registry results. This section does not apply to services provided to individuals under the age of 18, with the exception of parents of minor children in the consumer-directed program.

3. 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. 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.

4. 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.

5. Reduce quality sampling requirements for waiver services due to limited provider capacity to provide files for desk audit.

Flexibilities that will continue until July 31, 2020

The following flexibilities will expire on July 31, 2020.

1. Retainer payments may be made to providers of Adult Day Health Care, Group Day Services, Community Engagement, and Community Coaching. Retainer payments are retroactive to the date of the emergency on March 12, 2020 and shall be reimbursed at 65% percent of the current rates. Retainer payments can only be billed for members who are not receiving planned services or are not receiving the planned services at full utilization. The payment is only up to the number of units of authorized service. Retainer payments are available to agencies that are currently closed or operating at partial capacity with plans to completely re-open once it is safe to do so. Agencies with no plans to re-open do not qualify for the retainer payments and should notify the appropriate agencies, inform their participants, complete necessary discharge plans and submit a request to the appropriate entity to end the authorization. Providers that request and receive retainer payments attest that they can maintain and provide at least 65% staffing capacity upon re-opening after the emergency order expires.

   The ability to claim retainer payments will continue until July 31, 2020. Providers who maintain active authorizations for July 2020 maintain the ability to claim retainer payments for dates in July 2020. Per CMS guidelines, retainer payments may not exceed eighteen (18) consecutive days, which is the number of days for which the state authorizes a payment for "bed-hold" in nursing facilities or intermediate care facilities. To comply with this guideline, retainer payments may not be paid for the following dates of service: March 30, April 17, May 5, May 22, June 9, June 29 and July 17.

2. Allow providers and MCOs the option to conduct evaluations, assessments, and person-centered service planning meetings virtually or remotely in lieu of face-to-face meetings.

   All face-to-face requirements including initial health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings for CCC Plus Members in Nursing Facilities and in the Community are waived. All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are also waived until 7/31/2020. 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. (see #3 below for more LOCERI information.)

   All temporary suspensions of face-to-face requirements to conduct the health risk assessments, reassessments, interdisciplinary care team meetings, care planning meetings, and annual level of care evaluations may continue until July 31, 2020. It is important that in-person visits begin again starting August 1, 2020 to fully assess the health status of the member. Beyond July 31, 2020, in the event the member refuses the face to face visit, or the MCO or provider ascertains that the member or care coordinator's health is at risk by conducting the face to face visit due

to COVID-19, the MCO or provider must document the reason the face to face visit could not be made in the member's record.

3. Allow an extension of re-evaluations for level of care from twelve (12) to eighteen (18) months. 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. For CCC Plus Waiver members whose re-assessment is due on or before 7/31/2020, and whose previous face-to-face assessment is older than October 1, 2019, then the re-evaluation for level of care is extended six (6) months beyond the due date. The provider or the MCOs may use telehealth to conduct the level of care. Telephonic level of care assessments are not acceptable. If the provider or the MCO cannot visit the member or conduct the level of care via telehealth options (i.e., skype, facetime), the provider or MCO must document why the level of care could not be completed.

4. Allow an electronic method of service delivery (e.g, telephonic) to be provided remotely in the home setting for case management and monthly monitoring in order to meet the reasonable indication of need for services requirement in 1915 (c) waivers.

   Telephonic service delivery for case management face-to-face visits and other services that include a monthly or other regular monitoring component continue until July 31, 2020. To ensure the health and safety of vulnerable waiver members living in the community, face-to-face visits from providers charged with the oversight of community-based care will be reinstated after that date. 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. Beyond July 31, 2020, in the event the member refuses the face-to-face visit, or the support coordinator ascertains that the member or provider's health is at risk by conducting the face-to-face visit due to COVID-19, the support coordinator must document the reason the face-to-face visit could not be made in the member's record.

5. Allow In-home Support services to be delivered via an electronic method (i.e., "telehealth") of service delivery (e.g., telephonic or audio-visual connection). This allowance is only permitted for those authorizations in affect prior to the emergency declaration on March 12, 2020.

   Telephonic In-home Support service delivery will continue until July 31, 2020. To ensure the health and safety for vulnerable waiver members living in the community, face-to-face visits from providers charged with the oversight of community-based care will be reinstated after that date. Beyond July 31, 2020, in the event the member refuses the face-to-face visit, or the provider ascertains that the member or provider's health is at risk by conducting the face-to-face visit due to COVID-19, the provider must document the reason the face-to-face visit could not be made in the member's record.

Flexibilities that will continue until August 31, 2020

The following flexibility will expire on August 31, 2020.

1. 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.

   Parents of minor children and spouses will continue to provide care and be reimbursed for that support until August 31, 2020 as strict community infection prevention and control practices that limited paid caregivers to provide care in the home are being loosened during the re-opening process. Individuals who have taken advantage of this flexibility shall submit their timesheets to the appropriate fiscal agent no later than December 31, 2020.

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

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