Virginia Department of Behavioral Health & Developmental Services

DBHDS – Frequently Asked Questions

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What to do if someone presents with COVID-19 symptoms

Group homes and residential settings

Q 1.1: What do I do if a resident in our group home becomes symptomatic? What steps should be taken for residents and staff?

A 1.1: Please follow this congregate care guidance which includes new information from the Virginia Department of Health (4/20/20) regarding what residential settings should do to prevent the spread of COVID-19 and how to respond if a resident or staff member has a confirmed or suspected case of COVID-19. More information from VDH regarding testing at the state lab, including people with COVID-19 symptoms who live in congregate care settings, can be found here.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/congregate-care-guidance-dbhds-4.22.20.pdf
http://www.vdh.virginia.gov/coronavirus/health-professionals/vdh-updated-guidance-on-testing-for-covid-19/
http://www.vdh.virginia.gov/content/uploads/sites/182/2020/04/COVID_19_Congregate-Day-Programs-Guidance_final.pdf

Q 1.2: If we need to separate or quarantine an individual that may be sick, how do we do so while remaining in compliance with human rights regulations?

A 1.2: Technically, isolation meets the definition of "seclusion" in the human rights regulations. Isolation separates and restricts the movement of sick people (confirmed or suspected cases of COVID-19) from people who are not sick. This is different from quarantining a person, which refers to separating and restricting their movement to see if they become sick if they were exposed to someone with a confirmed or suspected case of COVID-19.

Based on a temporary waiver to the regulations by the Commissioner, when a provider determines the need to isolate an individual who has COVID-19 or is suspected to have COVID-19, or quarantine an individual who has been exposed to someone with COVID-19, the provider should:

- Explain the process to the individual or authorized representative (AR) if applicable;
- Document a conversation with the qualified healthcare professional recommending isolation;
- Indicate the symptoms or circumstances that warrant isolation;
- Notify DBHDS via email to the Regional Advocate; and
- Comply with internal emergency/infectious disease policies.

If the isolation or quarantine lasts longer than 7 days, the provider must document the need for the restriction in the individual's services record. Any individual or AR who believes his or her rights have been violated can make a complaint directly with the provider or through the advocate.

Q 1.3: Does a provider of a residential care have an obligation to notify a consumer that a peer or staff member has been diagnosed?

A 1.3: Yes, the provider should inform existing patients and potential new patients during the admission process that they have confirmed cases of COVID-19 in their program. The provider could post a sign within the residential setting, excluding the name and any other identifying information of the individual with the confirmed case.

Licensed providers

Q 1.4: What should licensed providers do if they come in contact with an individual suspected of having COVID-19?

A 1.4: The Virginia Department of Health (VDH) has developed a resources for healthcare providers. It includes guidance around identifying and reporting a person under investigation, including information around who is being tested for COVID-19 and when to be in touch with your local health department.

In addition, please review this information regarding when to report cases of COVID-19 in CHRIS.

Sources:
http://www.vdh.virginia.gov/content/uploads/sites/13/2020/03/Provider_FAQ_03082020.pdf
http://www.dbhds.virginia.gov/assets/doc/EI/serious-incident-reporting-of-covid-19.pdf

Q 1.5: How can direct support professionals be prepared?

A 1.5: This webinar recording from the National Alliance for Direct Support Professionals has helpful information around how some COVID-19 basics and how to engage individuals with disabilities in preventive measures.

Source:
https://www.youtube.com/watch?v=ud4Q4e_hcuw&feature=youtu.be

Preventing the spread of COVID-19

Q 2.1: What precautions can I take as a DBHDS-licensed providers to prevent COVID-19?

A 2.1: Please review guidance from the Office of Licensing here.

In addition, if you have not implemented or fully implemented tools and guidance related to screening, visitors, healthcare staff expectations, the Massachusetts General Hospital Novel Coronavirus Toolkit may be a helpful starting point. The Centers for Medicare and Medicaid Services (CMS) has also issued guidance for infection control in nursing facilities that may provide useful information.

Sources:
http://www.dbhds.virginia.gov/assets/doc/QMD/OL/03.05.2020-coronavirus-memo.pdf
https://www.massgeneral.org/assets/MGH/pdf/disaster-medicine/2019-Novel-Coronavirus-(2019-nCoV)-Toolkit-version-1.29.2020.pdf
https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

Q 2.2: What is the protocol for consumers who live with self-quarantined individuals who have not been confirmed to have COVID-19?

A 2.2: VDH specifies that individuals who have come in close contact with people who have confirmed cases of COVID-19 should follow these guidelines. Individuals who are at home with self-quarantined people should avoid close contact with those who are quarantined. When determining whether a service should be provided in-person, work with your agency to determine the best approach that considers the mental and physical health needs of the consumers you are serving.

Source:
http://www.vdh.virginia.gov/content/uploads/sites/13/2020/03/MM_Close_Contact_03082020.pdf

DBHDS on-site visits

Q 2.3: Will DBHDS be limiting on-site visits to reduce the potential spread of COVID-19?

A 2.3: DBHDS is aligning with guidance issued by CMS and reducing the frequency of on-site visits by licensing specialists and human rights advocates to those necessary to ensure the health and safety of individuals. Further details are available in this memo to providers. In addition, The Partnership for People with Disabilities will be pausing NCI visits to minimize the travel, exposure, and health risks associated with COVID-19.

Source:
http://dbhds.virginia.gov/assets/doc/QMD/OL/314-ol-ohr-covid-19-updates.pdf

Day support programs

Q 2.4: Should we close day support programs with fewer than 50 program participants?

A 2.4: Group day programs should not continue in typical format (i.e., groups from different households congregating together). If at all possible while providing day services, it would be most appropriate to try and keep the groups you are supporting to people they are already living with. As an example if you support three people from the same home, this might be one group your staff supports.

If a service closes, ensure individuals are informed of changes and know how to access essential services if needed. If the service is discontinued, ensure a crisis plan is in place. Check in with individuals on a regular basis via alternative means to provide brief support and ensure linkages to essential services. If receiving case management services, this contact can be made via case manager (i.e., program staff do not need to check-in with each individual).

More information can be found in DBHDS guidance for public and private providers here.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/2020.03.24-updated-guidance-for-public-and-private-providers.pdf

Q 2.5: Can day support services be authorized and provided by staff in a residential setting?

A 2.5: If a residential provider serves individuals who typically attend day support, but can no longer due to COVID-19, the provider should plan to provide appropriate services to the individuals during the daytime for the period in which they are unable to attend day support. These services should be provided by staff that have the appropriate training and qualifications to do so. The provider would need to contact DMAS to determine if the provision of these services would be payable as day support.

If a provider is licensed to provide both residential and day support services, and would like to have their day support staff come to the residential setting to provide day support services, this is permissible. The provider should notify their Licensing Specialist that they will be engaging in this practice and temporarily changing the location where day support services are offered.

Make sure to review DBHDS's information for congregate care settings here regarding screening of individuals entering the home.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/congregate-care-guidance-dbhds-4.22.20.pdf

Social distancing and restricting visitors

Q 2.6: What is the balance between isolating individuals from programming and their mental health when the individual is not a high risk?

A 2.6: The COVID-19 situation is evolving rapidly, and conditions are changing on a daily basis. Please continue to monitor the CDC and VDH websites and work with your agency to determine the best approach to balancing the mental and physical health needs of the individuals you serve

***Q 2.7: Are providers able to restrict visitors to prevent the spread of COVID-19?**

A 2.7: The Commissioner waived the human rights regulations around visitation. 12 VAC 35-115-50 states that each individual has the right to receive visitors. A waiver to this regulation allows a provider to limit visitation for all individuals in the program in order to maintain a safe environment. As Virginia has begun the phased re-opening process, providers may want to explore relaxing COVID-related limits on visitation. Providers may refer to VDH guidance for nursing home re-opening for examples of linking eased visitation restrictions with criteria based on the locality's current Forward Virginia Phase status and the provider's current readiness to implement infection control. While this guidance is not directly applicable to group homes or sponsored residential programs, it can serve as a useful guide.

Providers who have restricted individual's ability to travel outside of a residence may also consider easing these restrictions. In doing so they should consider what evidence is

needed to ensure that an individual understands and can practice the necessary infection control, hand hygiene, face covering, social distancing, etc. while away from the service setting. When considering off-site visitation, providers should have a plan in place to support the individuals return to the congregate setting which may involve additional screening and precautions (e.g., use alcohol-based hand rub and temperature scan upon entry) as well as the potential for quarantine. Please ensure appropriate notifications to individuals/authorized representatives and maintain the requirement for documentation and DBHDS oversight.

The community remains a source of outbreaks, which are still an active problem in the Commonwealth. Providers should incorporate VDH guidance/CMS guidance for visitation into their process planning and continue to adhere to recent mandates by the President and Governor to prevent community spread.

Sources:
https://www.vdh.virginia.gov/content/uploads/sites/182/2020/06/VDH-Nursing-Home-Guidance-for-Phased-Reopening-6.18.2020.pdf
https://www.cms.gov/files/document/qso-20-30-nh.pdf-0

Preventing COVID-19 among staff

Q 2.8: What should health care providers do if they come down with symptoms of COVID-19?

A 2.8: Health care providers who have signs and symptoms of a respiratory infection should not report to work. Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

- Immediately stop work, put on a facemask, and self-isolate at home
- Inform the clinical manager of information on individuals, equipment, and locations the person came in contact with
- Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment)

Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work.

Source:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Q 2.9: Will providers be penalized for closing administrative offices and allowing administrative staff to telework?

Q 2.9: No. Providers should encourage telework among administrative staff whose work can be completed remotely.

Q 2.10: Are direct support professionals considered essential personnel?

A 2.10: Yes. Still, any staff who are sick or who have come in close contact with an individual with COVID-19 should stay home.

Source:
http://www.vdh.virginia.gov/content/uploads/sites/13/2020/03/MM_Close_Contact_03082020.pdf

Telemedicine and providing services electronically

Q 3.1: Is it okay to conduct SIS assessments remotely?

A 3.1: Yes, SIS assessments may be conducted via video call or other electronic means. During the assessment, the assessor should make sure to be in a secure room (without others entering and exiting), and the individual being assessed should also be advised to be in a place that affords privacy.

Q 3.2: Will the Office of Licensing allow flexibility within Sponsored Residential providers to provide oversight through video or telephone if an extension is needed beyond 3 months?

A 3.2: We are allowing sponsored providers to conduct the quarterly inspections for each sponsored residential home as required by 12VAC35-105-1190 via video and this will be in effect until the end of the state of emergency. They should document in their records how these inspections were conducted.

Q 3.3: Has DMAS issued guidance around telemedicine flexibility during the public health emergency?

A 3.3: Yes, you can find more information from DMAS around use of telemedicine, including providing services via telephone and the waiving of certain program requirements here in guidance from 03/19/2020 and here in guidance from 03/27/2020.

Source:
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid-memo-03-19-2020.pdf

https://www.dmas.virginia.gov/files/links/5258/COVID%2019%20ARTS%20and%20BH%20Memo%203.27.20_FINAL.pdf

***Q 3.4: For services facilitation, can initial visits and transfer visits be performed virtually or by phone?**

A 3.4: Please see the recent DMAS memo from 6/26/20. Face-to-face visit requirements with members are waived for initial visits and transfers for personal care, respite, and companion services. Face-to-face visits can be replaced with telehealth methods of communication including phone calls and video conferencing until 7/31/20. 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 services.

Source:

DLA 20

Q 3.5: Can the DLA 20 assessment be completed telephonically?

A 3.5: Yes, DLA 20 assessments may be performed by telehealth or telephonic means.

- The DLA 20 assessment must be completed during the month it is due if the consumer has been seen (through the use of telehealth, in person, or spoken to by phone).
- If the consumer has NOT been seen within the last 30 days, complete the DLA 20 at the time of the next interaction. NOTE: This will not change the timeframe for the next DLA 20. The DLA 20 should align with the Quarterly even if there is a truncated period between due to absenteeism.

Staffing

Pre-screeners and emergency services

Q 4.1: Should emergency services pre-screeners become compromised or quarantined, can Community Services Boards leverage other licensed clinicians on staff to complete necessary prescreens?

A 4.1: Please review guidance for CSB emergency services staff regarding this question here.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/dbhds-emergency-services-covid-19-guidance-updated-3-19-20.pdf

Q 4.2: Will alternative transportation still be available?

A 4.2: Patients needing transportation to an inpatient psychiatric facility will be able to access alternative transportation by G4S unless the patient has symptoms of COVID-19. More information from G4S about their response to COVID-19 is available here.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/covid-19_g4s-healthcare-continued-response-and-guidance.pdf

Q 4.3: Is there any flexibility around training for Certified Preadmission Screening Clinicians?

A 4.3: Please see recent guidance (4/20/20) regarding the preadmission screening certification process?

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/dbhds-guidance-on-certifying-cpsc.pdf

Transfer of direct care staff

Q 4.4: As a licensed provider, may I transfer direct care staff between licensed services based on need and staff availability?

A 4.4: The Office of Licensing anticipates that provider staffing struggles will be exacerbated by the ongoing COVID-19 public health crisis. Providers who operate multiple licensed services, each with its own unique staffing portfolio, may find it necessary to reallocate staff from one licensed service to another licensed service in order to accommodate staffing shortages in one or more of the provider's licensed services. Please find below clarification regarding the regulatory requirements for these staff sharing arrangements.

- As you know, providers must submit documentation to run criminal history background checks and central registry searches for any new applicant who accepts employment in any direct care position per Virginia Code § 37.2-416. In addition, per recent changes to the Virginia Code § 37.2-408.1, results of the criminal history background check must be received *prior to* permitting a person to work in the children's residential facility.
- Under the Licensing Regulations, when a provider operates multiple licensed services, the provider *may reallocate* staff in direct care positions from one licensed service to another licensed service *without submitting documentation to run a new criminal history background check and central registry search*. This would constitute a re-allocation of existing staff, and not a newly hired employee. The provider should ensure, however, that documentation of the criminal history background check and registry search that was completed at the initial point of hire is maintained in the individual's personnel file.
- When a licensed provider reallocates staff from one licensed service to another, they shall ensure that the staff has received all necessary orientation and training for the new position pursuant to 12 VAC 35-105-440 & 12 VAC 35-46-310. If the orientation/training requirements for the two positions are the same, and the employee has already completed all required orientation/training for the prior position, no additional training is necessary. In addition, providers shall ensure that the reallocated staff still meets the minimum qualifications of the specific direct care position as determined by the job description for the position pursuant to 12 VAC 35-105-420 & 12 VAC 35-46-290.

Background checks

Q 4.5: In the event of a temporary layoff, will providers need to obtain new background checks when employees return to providing services?

A 4.5: If a provider terminates an employee, the provider will need to submit all required documentation in order to obtain a criminal history background check and central registry search when the employee is re-hired.

- If a provider temporarily places an employee on leave or chooses not to schedule an employee to work during this emergency period, then the provider will not need to obtain a new background check or central registry search when the employee returns to work.

Q 4.6: If a provider would like to hire direct care staff who was employed by another licensed provider, do they still need to submit proper documentation for background checks and central registry searches?

A 4.6: Anytime a provider hires direct care staff, the provider must submit all documentation in order to conduct a criminal history background check and central registry search pursuant to Virginia Code § 37.2-416.

- The employee must also submit to the provider a disclosure statement stating whether they have ever been convicted of or are the subject of pending charges for any offense pursuant to 12 VAC 35-105-400.
- The hiring provider shall maintain the disclosure statement from the applicant stating whether he has ever been convicted of or is the subject of pending charges for any offense; and documentation that the provider submitted all information required by the department to complete the criminal history background checks and registry checks searches, memoranda from the department transmitting the results to the provider, and the results from the Child Protective Registry check search.
- For providers of non-children's residential services, the provider may allow staff to work in the period while they wait for the results of the background check/central registry search to be returned, if this is what their policies allow for.
- If the provider intends to temporarily amend their policy during this emergency period to allow staff to work prior to the transmittal of the results, they should alert their Licensing Specialist to this temporary change.
- *Please remember that per Virginia Code § 37.2-408.1, providers of children's residential services are prohibited from allowing all volunteers, contractors, and staff to work in the service until the results of the criminal history and central registry searches have been returned.*

Q 4.7: What steps should we take if Fieldprint temporarily closes their office(s) in our area?

A 4.7: It has recently come to our attention that Fieldprint has closed several of their offices throughout the Commonwealth, making it impossible for direct care staff in some areas to submit fingerprints for background checks. If a non-children's residential service provider finds themselves in an area where Fieldprint has temporarily closed its office, the provider shall take the following steps when bringing on new staff:

- Providers shall continue to require all new staff to submit a disclosure statement stating whether the person has ever been convicted of or is the subject of pending charges for any offense (12 VAC 35-105-400.B.). In addition, the provider shall address what actions it will take should it be discovered that a person has a founded case of abuse or neglect or both, or a conviction or pending criminal charge.
- Providers shall designate an employee within management to review each disclosure statement against this list of barrier crimes.

- Once the reviewer has completed their review, they shall sign the disclosure statement certifying that they have reviewed the disclosure statement and have not identified any barrier crimes. If the reviewer does identify barrier crimes within the disclosure statement, the employee shall not be permitted to work before the results of their criminal history background check have been returned.
- The provider shall maintain the employee's signed disclosure statement as well as the notice sent to the provider from Fieldprint stating that their local office is closed within the employee's personnel file.
- Once the abovementioned steps have been taken, if the provider allows the employee to begin working in non-children's residential licensed services prior to receipt of the employee's criminal history background check results, DBHDS will not cite providers for violation of Virginia Code §§ 37.2-416, 37.2-506, or 37.2-607.
- Please note that employees will be expected to make the first available appointment once the local Fieldprint offices re-open. Failure to do so will result in citation from the Office of Licensing.
- For individuals who previously scheduled appointments at a Fieldprint location that has since closed, Fieldprint has stated that such individuals will be contacted by its support team to reschedule at another nearby facility.

Source:
http://www.dbhds.virginia.gov/assets/doc/hr/biu/attachment-2rev072019.pdf

DSP orientation and competencies

Q 4.8: Will the requirements for DSP Orientation and Competencies be waived?

A 4.8: First, concerted effort has gone into streamlining the basic DSP competencies so that they are more consistently applied and less time-intensive to complete. To prevent delaying provider access to the streamlined version, the updated competency documents are available here under the header "March 6, 2020 optional for use". They may be used for new hires or for existing staff, or providers may choose to use the existing version of the basic competencies document until DD Waiver regulations are effective.

- Next, staff who were hired within six months prior to March 12th, 2020 are reaching the end of the 180 day timeframe required for proficiency. DMAS will consider extending the date for these staff past the 180 days if documentation is on file that circumstances prevented the confirmation of proficiency during the state of emergency. This documentation should be maintained by the agency in the event of a DMAS Quality Management Review.
- It should be noted that competencies are not portable across agencies and any staff move 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.

Source:
http://www.dbhds.virginia.gov/developmental-services/provider-development

Staffing ratios

Q 4.9: Is the Office of Licensing allowing flexibility with staffing for residential and inpatient if there are shortages due to COVID-19? Such as lifting any staff/patient ratios?

A 4.9: DBHDS recognizes that the pandemic has created a number of challenges for providers, including ensuring that sufficient staff are available to meet the needs of the individuals they serve. DBHDS does not mandate specific staffing ratios, with the exception of children's residential services.

- The Licensing Regulations for children's residential facilities state that at all times the ratio of staff to residents shall be at least one staff to eight residents for facilities during the hours residents are awake, except when the department has approved or required a supervision plan with a different ratio based on the needs of the population served. Providers requesting a ratio that allows a higher number of residents to be supervised by one staff person than was approved or required shall submit a justification to the department that shall include: a. Why resident care will not be adversely affected; and b. How residents' needs will be met on an individual as well as group basis.
- If a children's residential provider would like to deviate from the required staffing ratio, they will need to submit a request to their Licensing Specialist including how resident care will not be adversely affected and how residents' needs will be met on an individual as well as group basis. The Office of Licensing understands that these requests will be time sensitive and will be prioritizing them accordingly.
- For acute inpatient psychiatric services, the Licensing Regulations do not include specific staffing ratios. The regulations require that providers admit only those individuals whose service needs are consistent with the service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals served receiving services. In addition, the provider must have adequate staff to safely evacuate all individuals during an emergency. If a provider must reduce staffing levels below those described in their program description, they should notify their specialist of the change as soon as possible.

Q 4.10: Can the Sponsored Residential direct support professional to individual ratio be temporarily changed from 1:2 to 1:3 during the state of emergency?

A 4.10: The Office of Licensing will not be granting a blanket exemption to this regulatory requirement. If a sponsored location has an identified need to increase capacity from 2 to 3 individuals due to the emergency at hand, and does not feel that the increased capacity will affect the health and safety of individuals served, they may submit a variance request directly to their Licensing Specialist.

Returning to work

Q 4.11: When should staff return to work if they have been out due to a suspected or confirmed case of COVID-19?

A 4.11: Providers should follow the CDC's return to work criteria for healthcare providers, available here.

Source:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Services and programs

Medication

Q 5.1: Will patients be able to access their medications if non-essential healthcare visits are postponed?

A 5.1: Yes, pharmacists have some discretion regarding dispensing of new prescriptions or refills. The Virginia Board of Pharmacy has issued information for pharmacists here.

Source:
https://www.dhp.virginia.gov/Pharmacy/news/PharmacyCoronavirusInformation3-13-2020.pdf

Q 5.2: Is there any guidance around dispensing clozapine during the public health emergency?

A 5.2: Yes, DBHDS is supportive of FDA guidance related to clozapine dispensing during the COVID-19 pandemic and has issued this memo for clozapine prescribers with additional information.

Source:
http://dbhds.virginia.gov/assets/doc/EI/dbhds_clozapinememo_040820.pdf

Case management

Q 5.3: Will the expectation for 30- and 90-day face-to-face case management visits during the COVID-19 outbreak be waived?

A 5.3: The 90-day face to face visits are a targeted case management requirement under CMS. This guidance from DMAS outlines how some face-to-face requirements can be waived. Information regarding developmental disability waivers starts on page 7.

The 30-day face-to face-visits are a DBHDS requirement pursuant to the Settlement Agreement related to individuals with enhanced support needs. DBHDS supports the suspension of 30-day face-to-face visits throughout the Governor's "stay at home" order so long as there is not an emergency that would indicate a visit was needed and it does not violate the CMS requirement for a 90 day face-to-face. It is expected that, in lieu of the 30-day face-to-face visit, the case manager will conduct a telephonic review to address areas of need similar to what they would do during a face-to-face visit. DBHDS will re-evaluate this suspension as the 30 day period nears it completion and will provide additional guidance at that time.

Source:
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid-memo-03-19-2020.pdf

PACT

Q 5.4: Are there any recommendations for PACT teams?

A 5.4: Please refer to this document, which was sent directly to all PACT programs. In addition, this FAQ includes information on leveraging nurse practitioners on PACT teams.

Source:
http://dbhds.virginia.gov/assets/doc/EI/covid-act-recs_3_13.pdf

Discharge

Q 5.5: If a client discontinues services after a possible quarantine, can we pick up services afterwards as long as clinically appropriate?

A 5.5: Individuals who have not participated in a service in 30 days do not have to be discharged from the service. If the service authorization period ends, a new authorization request shall be made for the service to continue.

Waiver individuals who receive fewer than once service per month will not be discharged from a HCBS waiver. They shall receive monthly monitoring when services are furnished on less than a monthly basis. More information on this can be found in the DMAS Medicaid Memo from 4/22/20.

The Office of Licensing regulations do not require discharge if an individual does not receive services for 30 days. If an individual temporarily suspends services, we would expect for the provider to re-assess the individual when services begin again to ensure that the services previously offered are still appropriate.

Sources:
https://www.dmas.virginia.gov/files/links/5258/COVID%2019%20ARTS%20and%20BH%20Memo%203.27.20_FINAL.pdf
https://www.dmas.virginia.gov/files/links/5285/4.22.2020_DD%20and%20CCC%20Plus%20Waivers%20Provid%20Flex.%20COVID%2019%20Memo_FINAL.pdf

Services for NGRI population

Q 5.6: How should Community Services Boards serving clients who have been adjudicated not guilty by reason of insanity (NGRI) and are on conditional release manage drug testing?

A 5.6: NGRI individuals are released under a conditional release order from the court. The order mandates what the individual will do in order to maintain his/her health as well as what services and supports shall be provided to the individual to help them maintain safety in the community. CSBs must assess an individual's risk factors and their individual Conditional Release Plan to determine which conditions must continue as written and which of the conditions can be safely adjusted during the crisis. They should adhere to their agency's guidance on office-based and home-based meetings with clients when making these decisions. Historically, relapses into substance misuse is a major factor contributing to both revocation of conditional release as well as future acts of aggression. The CSB should assess how pertinent ongoing drug testing is to the individual's recovery. If the individual is early in his/her recovery or requires external encouragement to maintain his/her sobriety, then the CSB should determine how to continue testing while

minimizing risk to staff/others. If the CSB determines that the individual does not require the ongoing testing then it would behoove the CSB to write to the court notifying them of any changes made to the conditions of the Conditional Release Plan during the COVID-19 crisis.

Services for DD population

Q 5.7: Where can I find more information about providing developmental disability (DD) waiver services during the COVID-19 outbreak?

A 5.7: Information for providers supporting individuals who receive DD waivers can be found here (updated 4/2/20). Additionally, the Medicaid Memo from 4/22/20 has more information regarding DD waiver provider flexibilities including information around legally responsible individuals providing personal care services, flexibility around training and reporting requirements, waiving of certain face-to-face visit requirements, and more.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/4.2.2020-covid-faqs-for-dd-providers.xlsx
https://www.dmas.virginia.gov/files/links/5285/4.22.2020_DD%20and%20CCC%20Plus%20Waivers%20Provid%20Flex.%20COVID%2019%20Memo_FINAL.pdf

Q 5.8: Can providers request a service authorization to adhere to the original expiration date, or are service authorization extensions mandatory?

A 5.8: Service authorization (SA) staff will not be changing the DMAS automatically extended end dates. If services are due for renewal during that two month window, SA staff will authorize them with a start date of the day following the auto-extended end date *unless* an increase in services is being requested. In that latter case, the start date for the increase will be honored (assuming all proper documentation is present). This does not pose a problem with the per diem residential services that are limited to 344 days of billing per ISP year due to the fact that DMAS and DBHDS have implemented an allowance for providers of those services to continue to bill during the two month service authorization extension without penalty.

Individual service plans (ISPs)

Q 5.9: Is the intention that the individual service plan (ISP) and the provider's plan for support (PFS) dates remain unchanged even with the extension of authorizations by 60 days?

A 5.9: Dates on the ISP, PFS, and quarterlies should stay on the same schedule, regardless of any authorization extension.

Q 5.10 Do ISPs and PFSs for the DD population need to be updated if the service is being provided via remotely via phone or video conferencing?

A 5.10: The ISP and PFS should only be updated if the methodology of service delivery changes what is delivered. If the service remains the same even as it is provided via phone or videoconferencing, the ISP and PFS do not need to be updated. The notes should, however, reflect the delivery method and indicate if the service was provided via phone or videoconferencing.

Community Engagement

Q 5.11: To increase group day hours to account for losses in community engagement, do we need to send in new authorization requests via WaMS?

A 5.11: Providers would need to submit a modification to current group day request to increase hours. There is no need to discontinue Community Engagement authorization, but the provider may need to adjust its group day hours back down once returning to providing both services.

Impact of COVID-19 on mental health

Q 6.1: What considerations should be made regarding the impact of COVID-19 on mental health?

A 6.1: The CDC has issued some guidelines regarding mental health and coping in light of the COVID-19 pandemic. In addition, please refer to guidance posted by DBHDS, The Center for the Study of Traumatic Stress, and SAMHSA with information around taking care of behavioral health during social distancing, quarantine, and isolation.

Sources:
https://www.cdc.gov/coronavirus/2019-ncov/about/coping.html
http://dbhds.virginia.gov/assets/doc/EI/covid-act-recs_3_13.pdf
https://www.cstsonline.org/assets/media/documents/CSTS_FS_Mental%20Health%20and%20Behavioral%20Guidelines%20for%20Response%20to%20%20a%20Pandemic%20Flu%20Outbreak.pdf
https://www.samhsa.gov/sites/default/files/tips-social-distancing-quarantine-isolation-031620.pdf

*Face masks and personal protective equipment (PPE)

Q 7.1: How can my agency obtain personal protective equipment (PPE) for staff and clients?

A 7.1: Currently many PPE including face masks and eye goggles are in short supply. It is possible that companies specializing in other fields that require PPE may have inventory. For example, restaurant supply companies may still have latex gloves and eye goggles. PPE should be prioritized for healthcare workers who are coming into direct contact with individuals with known or suspected COVID-19. Other healthcare workers can take everyday precautions such as regular hand washing, covering coughs and sneezes, and staying home when sick.

While not considered PPE, the CDC has recommended that all individuals in public settings wear cloth face coverings to reduce the risk of transmission of the virus, and the Governor's Executive Order Number 63 (5/26/20) requires individuals to wear face coverings in public indoor settings. Exceptions include when removal of the mask is necessary for the provision of medical services or when the individual has a health condition that prevents use of a mask.

Source:

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html

https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-63-and-Order-Of-Public-Health-Emergency-Five---Requirement-To-Wear-Face-Covering-While-Inside-Buildings.pdf

Q 7.2: Are there alternatives that can be utilized if we are unable to obtain CDC-recommended respirators?

A 7.2: CDC guidance indicates that facemasks may be used as an alternative to respirators in specific situations. In addition, the CDC has received emergency authorization through the FDA to allow the use of respirators that are approved for industrial use, to be utilized in healthcare settings.

Sources:
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-and-cdc-take-action-increase-access-respirators-including-n95s

***Q 7.3: Do all healthcare workers need to be wearing facemasks?**

A 7.3: Healthcare workers involved in the care of patients with known or suspected COVID-19 should take precautions by adhering to the CDC's Standard, Contact, and Airborne Precautions including eye protection, respirators, gowns, gloves, etc. CMS has released additional guidance around the use of facemasks and respirators for these healthcare workers.

Those staff who are not involved in the care of patients with known or suspected COVID-19 should take everyday preventive actions. Additionally, while not considered PPE, the CDC has recommended that all individuals in public settings wear cloth face coverings to reduce the risk of transmission of the virus and the Governor's Executive Order Number 63 (5/26/20) requires individuals to wear face coverings in public indoor settings.

Sources:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html
https://www.cms.gov/files/document/qso-20-17-all.pdf
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html

https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-63-and-Order-Of-Public-Health-Emergency-Five---Requirement-To-Wear-Face-Covering-While-Inside-Buildings.pdf

Q 7.4: Can a provider require an individual to wear a mask/face covering?

A 7.4: Consistent with their responsibility to provide services in a safe environment, providers may require individuals to wear a mask or face covering during the provision of services. The decision to require face coverings in a program should be based on the service setting and balanced with all other infection control strategies such as social distancing, hand washing stations, and plexiglass barriers where appropriate. Providers must have policies to address the use of face coverings in the program and inform individuals/authorized representatives of this requirement prior to service delivery. These policies must take into account individuals who choose not to wear a face covering or for whom it is contraindicated as well as individuals that do not have the ability to provide their own mask/face covering. Providers must also document individual/AR consent or objection to wearing face coverings as well as communication from medical professionals

about contraindications in the services record. Providers that implement a policy requiring a face mask, should assist any individual who does not want to wear a face mask to find alternative services.

Source:
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-faq.html

***Q 7.5: Does this mean a group home can ask an individual to move out if he or she refuses to wear a face mask?**

A 7.5: No. This guidance recognizes that programs providing services in a community-based setting may set such requirements for safety and individuals/AR's may decide not to participate based on his/her choice not to wear a mask. When the choice is made not to continue with a service an individual's entire support team, including the provider, should assist in identifying alternative services to meet the individual's needs and preferences, to the extent possible.

***Q 7.6: Can providers use plexiglass in vehicles when transporting individuals?**

A 7.6: Providers have a responsibility to maintain a safe environment, which extends to use of transportation in the delivery of a service. Providers should be advised that the use of plexiglass for the purpose of infection control in a vehicle may have other unintended effects.

If a provider determines to utilize the plexiglass they must inform individuals ahead of time to include information about how it will impact them and what the provider will consider in order to discontinue the usage. The provider should consider some level of assessment to ensure individuals can tolerate the plexiglass (i.e. will not have an adverse behavioral reaction or trauma), and the provider must not compromise the safety mechanisms in the vehicle (i.e. plexiglass cannot take place of seat belt or cover access to air flow by a vent).

Additionally, DMAS and the MCO NEMT Programs are working on NEMT criteria for when day support and facilities open back up. This information will have suggested seating arrangements for different types of vehicles that should help with infection control.

Trainings

Q 8.1: Will the Office of Licensing grant at least a 3-month extension of competencies and annual trainings?

A 8.1: Licensing Regulation 12VAC35-105-450 requires all providers, other than children's residential providers, to develop a training policy that addresses the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics.

- If the provider intends to modify the frequency of retraining during this emergency period, they will need to amend their policy or create a new emergency policy to reflect this decision.
- The provider will need to provide notice to their Licensing Specialist of the policy change.

- Please note that per Licensing Regulation 12 VAC 35-105-450, there shall be at least one employee or contractor on duty at each location who holds a current certificate (i) issued by the American Red Cross, the American Heart Association, or comparable authority in standard first aid and cardiopulmonary resuscitation (CPR) or (ii) as an emergency medical technician. A licensed medical professional who holds a current professional license shall be deemed to hold a current certificate in first aid, but not in CPR. The certification process shall include a hands-on, in-person demonstration of first aid and CPR competency. In addition, for children's residential facilities, regulation 12 VAC 35-46-310.A.4. states that within 30 days following their begin date, all staff working with residents shall be enrolled in a standard first aid class and in a cardiopulmonary resuscitation class facilitated by the American Red Cross or other recognized authority, unless the individual is currently certified in first aid and cardiopulmonary resuscitation. These requirements remain in effect during the COVID-19 emergency period.
  i. During the COVID-19 emergency, the Red Cross is recognizing certification 120 days post-expiration and the Heart Association is doing so for 120 days post-expiration as well. More information can be found on the Heart Association and Red Cross websites.
  ii. If a staff member was previously CPR certified, but their certification has expired during the emergency period, DBHDS will honor the certification extension put into place by the American Red Cross, the American Heart Association, or comparable authority in standard first aid and cardiopulmonary resuscitation (CPR) or as an emergency medical technician. Certifications granted by agencies through virtual "hands on" training will be honored by DBHDS during the state of emergency so long as every attempt is made to have at least one staff member present who has completed full certification with a face-to-face, hands-on component. All providers should ensure staff are trained to immediately call 911 when a person is determined to be unresponsive or whenever they feel there might be a life-threatening situation (a training resource on the importance of calling 911 is available here).
- Distance learning (definition: a method of studying in which lectures are broadcast or classes are conducted by correspondence or over the Internet") opportunities are continuing to grow, but for the topics and components of training that require hands on observation or competency check, they cannot not be completed via distance learning.
  iii. DBHDS licensed providers need to follow the guidelines of the qualified providers of any specific training such as CPR, First Aid and Crisis Prevention Intervention (CPI) Training. Each of these qualified training providers has policies around distance learning and new/renewal certifications.
    1. For example, the Heart Association life saving training courses are available online. These courses that involve only cognitive learning can be completed entirely online. For courses that teach CPR, they require that the student complete an in-person skills practice and testing session with a Heart Association instructor after they complete the online portion. The Red Cross has similar offerings.

2. Several common behavior intervention certification programs also have a COVID-19 response/resources available on their website:
    a. MANDT: https://www.mandtsystem.com/the-mandt-system-leadership/
    b. CPI: https://www.crisisprevention.com/Blog/Important-Coronavirus-Update-From-CPI
    c. TOVA: https://therapeuticoptions.com/covid19/
    d. Handle With Care: https://handlewithcare.com/handle-with-care-covid-19-update/

iv. For Medication Aide Training (32 hour curriculum and additional modules approved for DBHDS licensed providers) the same applies; for the topics and components of Medication Aide training that require hands on observation or competency check, these cannot not be completed via distance learning.

- Any questions related to competencies should be directed to Heather Norton, Acting Deputy Commissioner, Developmental Services, DBHDS, at Heather.Norton@dbhds.virginia.gov or Ann Bevan, Director, Division of Developmental Disabilities, DMAS at ann.bevan@dmas.virginia.gov.

Q 8.2: Should providers hold medication administration refresher trainings for groups of employees?

A 8.2: Providers are expected to follow their own policies related to medication administration training. If a provider would like to extend the period for which they require staff to receive refresher training, they should include this in an emergency protocol and alert their Licensing Specialist to the change. If trainings are scheduled, providers should adhere to CDC guidelines regarding social distancing, sanitizing common surfaces, and other infection control processes.

DBHDS licensing regulations

Initial applications

Q 9.1: Are applications being processed? Will Licensing Specialists be doing inspections?

A 9.1: The Office of Licensing is continuing to process initial applications. For residential services, the Licensing Specialist will speak with the applicant when they call to schedule their on-site inspection to confirm that no individuals are currently residing in or receiving services within the home. If this is the case, the Licensing Specialist will move forward with conducting the onsite inspection necessary to issue a conditional license.

Conditional licenses and renewal applications

Q 9.2: My agency is on a conditional license for community coaching, will this be extended or does the agency have to stop billing?

A 9.2: During this emergency period, the Office of Licensing will continue to process renewal applications per our March 14, 2020 correspondence.

- If your agency is on a conditional license, you should submit a renewal application. Once you submit this application, your Licensing Specialist will request for you to send additional information and documentation, as necessary in order to determine compliance with the Licensing Regulations.

- In most cases we will be able to issue a new license without an on-site visit. If your Licensing Specialist determines a new license cannot be issued without conducting an on-site review, we will handle these situations on a case-by-case basis.

Source:
http://www.dbhds.virginia.gov/assets/doc/QMD/OL/314-ol-ohr-covid-19-updates.pdf

Communication with DBHDS

Q 9.3: What kinds of changes do DBHDS-licensed providers need to notify the Office of Licensing about?

A 9.3: As always, DBHDS-licensed providers are expected to inform their Licensing Specialist of any major changes to their service(s) during this emergency period. This includes:

i. Temporary or permanent closure of services;
ii. Temporary or permanent closure of locations;
iii. Changes to administrative staff;
iv. Changes to service description; and
v. Implementation of any emergency policies or protocols.

CHRIS Reporting

Q 9.4: If during the provision of services it is determined that a patient or individual may have COVID-19 symptoms and the patient is presumptive positive or laboratory confirmed to have COVID-19, is a hospital required to report the case as a Level II Serious Incident in CHRIS?

A 9.4: Providers licensed by the DBHDS Office of Licensing are required to enter incidents into CHRIS. Please review this guidance regarding when to report cases of COVID-19 in CHRIS.

If DBHDS licenses the unit of the hospital where the condition was identified, or the individual received treatment, the hospital will need to enter the incident into CHRIS as a Level II Serious Incident.

Source:
http://www.dbhds.virginia.gov/assets/doc/EI/serious-incident-reporting-of-covid-19.pdf

Q 9.5: Is the hospital or other provider required to do a root cause analysis for each case reported to CHRIS as defined above in bullet 1 and 2?

A 9.5: No. The Office of Licensing is deeming that an individual contracting COVID-19 is beyond the provider's control. In such cases, the provider should make sure that their CHRIS report includes a description of the event and any additional precautions taken by the provider to mitigate risks to other patients.

Q 9.6: What is the intended outcome/goal of reporting these cases in CHRIS?

A 9.6: The goal is for DBHDS to be able to monitor the ongoing situation regarding COVID-19 infections and potential hotspot areas where additional resources may be necessary.

Physical examinations and PPD tests (TB tests)

Q 9.7: Can providers exceed deadlines for physical examinations and PPD tests when unable to see a doctor?

A 9.7: If an individual is unable to attend their routine physical exam appointments with a physician due to limited hours or appointment cancellations imposed by doctors' offices and clinics, the provider shall document evidence as to why the appointment could not occur within the individual's progress notes. All attempts shall be made to reschedule the individual's appointment as soon as possible.

TB Testing

Q 9.8: What guidance is there around tuberculosis screening and testing for healthcare providers?

A 9.8: Guidance around who can ask questions included in a TB risk assessment as well as who can assess risk for TB infection and/or disease based on the answers is available from VDH here. At this time, current licensing requirements for TB screening remain in place; DBHDS will continue to monitor.

Source: http://www.vdh.virginia.gov/content/uploads/sites/175/2020/02/Tuberculosis-Screening-and-Testing-for-Occupational-Purposes_2020.pdf

Other licensing questions

Q 9.9: Can the 90-day operating capital requirement be waived temporarily during the state of emergency?

A 9.9: The requirement for 90 days of operating capital exists to assist providers during emergency periods such as this. The Office of Licensing will not be actively citing providers for failure to maintain 90 days of operating expenses during this period.

Q 9.10: Can the licensure process be expedited to allow for use of additional, available space?

A 9.10: Yes, please see these FAQs to learn more.

Q 9.11: Must providers adhere to normal discharge and admission processes during the state of emergency including signed notifications by guardians?

A 9.11: Providers are always expected to provide notice to an individual's authorized representative regarding discharge, and make all attempts possible to include the authorized representative in discharge planning. During this period, if a provider is unable

to get signed verification from an authorized representative, they should attempt to receive confirmation over the phone or via e-mail. If a provider is not able to receive confirmation prior to moving, they shall document all attempts to receive confirmation within the individual's record.

The requirements regarding discharge and assessments are in place to protect the health and safety of individuals served and will not be waived during the emergency period.

For providers of residential services for individuals with developmental disabilities, the individual's case manager may look over their current assessment and ISP and confirm in writing to the new provider that all information is still accurate.

Q 9.12: Can an individual be temporarily transferred between licensed services during the state of emergency when a provider has multiple licensed services?

A 9.12: Individuals should never be placed into a service for which admission is not appropriate based on the individual's needs. If a provider is no longer able to provide the appropriate level of services to an individual due to COVID-19, they should consider the following options:

1. If, due to the COVID-19 emergency, a provider is unable to provide all required aspects of a service, including service hours, they may consult with their Licensing Specialist about a temporary service modification to continue to serve individuals with the resources at hand during the emergency (all service modifications must be approved by the specialist prior to implementation);
2. Temporarily suspend services to the individual; or
3. The individual should be formally discharged and admitted to another provider who can provide this service.

If a provider needs to transfer an individual from one licensed service location to another licensed service location (same service, different location) they should fill out a transition summary pursuant to 12VAC35-105-691.

Expanding capacity

Q 9.13: Can licensed residential providers serving individuals with confirmed or suspected cases of COVID-19 temporarily open an additional location and/or expand bed capacity during the state of emergency?

*A 9.13: Yes, licensed residential providers serving individuals with confirmed or suspected cases of COVID-19 may temporarily open an additional location or expand bed capacity for a residential service that they are already licensed to provide during the COVID-19 emergency. To do so, providers must complete this service modification form and await approval from their Licensing Specialist.

Please note, the support coordinator/case manager should complete a Regional Support Team (RST) referral as well as a Virginia Informed Choice form if the individual is moved to another location.

Q 9.14: Can inpatient psychiatric hospitals get approval to temporarily flex beds currently used for licensed for children to provide services to adults or vice versa?

A 9.14: Yes, during the COVID-19 state of emergency, licensed inpatient psychiatric providers may temporarily flex currently licensed beds between adult and children populations if there is an identified COVID-19 related need to do so. More information around the requirements and process for requesting approval for this temporary bed flexing is available here.

Source:
http://dbhds.virginia.gov/assets/doc/EI/dbhds-flexing-beds-during-covid-19-4-17-20.docx

Nurse Practitioners on PACT Teams

Q 9.15: If a PACT provider is unable to employ a psychiatrist due to the COVID-19 emergency, may we employ a nurse practitioner instead?

A 9.15: Pursuant to 12VAC35-105-1370.1.f, a Program of Assertive Community Treatment (PACT) team must include a psychiatrist who is board certified in psychiatry or who is board eligible in psychiatry and is licensed to practice medicine in Virginia. For each individual served, 20 minutes of psychiatric time for each individual served must be maintained. Additionally, the psychiatrist shall be a fully integrated team member who attends team meetings and actively participates in developing and implementing each individual ISP.

PACT teams frequently have difficulty satisfying the requirements of 12VAC35-105-1370.1.f due to a shortage of qualified individuals. The ongoing COVID-19 public health crisis has exacerbated this and other preexisting personnel challenges. In recognition of these challenges, and in recognition of the critical need to continue providing PACT services to individuals in the community during the public health crisis, DBHDS will liberally exercise its authority during the crisis, pursuant to 12VAC35-105-120, to grant temporary variances to providers of PACT services, which shall last throughout the COVID-19 public health emergency period and for up to 30 days after the emergency period ends, under the following circumstances:

1. The provider is unable, in whole or in part because of the COVID-19 public health emergency, to employ a psychiatrist as defined in 12VAC35-105-1370.1.f; and
2. The provider is able to employ a psychiatric nurse/mental health practitioner, licensed by the Board of Nursing and operating within the scope practice as defined by 18VAC90-30-120, who shall otherwise meet the requirements of 12VAC35-105-1370.1.f; and
3. The provider submits a completed provider variance request form explaining why the variance is being requested. For your convenience, the department has already included language within the form related to the

need for a temporary variance based on the COVID-19 emergency. The department must approve a variance prior to implementation.

Source:
http://dbhds.virginia.gov/assets/doc/EI/4.13-pact-covid-19-variance-request-form.docx

"Stay at home" guidance

Q 10.1: Based on the Governor's recent "stay at home" order, is my organization considered "essential"?

A 10.1: The Governor has issued Executive Order 53, limiting the interactions of non-essential business throughout the Commonwealth in an effort to prevent the spread of COVID-19. You can find a copy of the order linked here, as well as an FAQ about the order. While the Governor's announcement only includes broad categories of what would constitute essential services, please note essential services cover the range of mental health, substance-use disorder, or developmental services that are licensed, contracted, or funded by DBHDS. Any efforts providers can deploy to safely provide support to their clients, whenever possible, should be fully exercised. Examples may include providing an extended duration of medication per pick up, limiting the number of individuals present in groups or activities, maintaining social distance, and utilizing telemedicine whenever possible. More information about expansion and flexibilities surrounding telemedicine during the COVID-19 emergency can be found here.

Guidance from DBHDS following the order for public and private providers is available here.

Sources:
https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-53-Temporary-Restrictions-Due-To-Novel-Coronavirus-(COVID-19).pdf
https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/pdf/Frequently-Asked-Questions-Regarding-EO-53.pdf
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid-memo-03-19-2020.pdf
http://www.dbhds.virginia.gov/assets/doc/EI/2020.03.24-updated-guidance-for-public-and-private-providers.pdf

Medicaid coverage

Q 11.1: Will Medicaid members be able to keep their coverage at least through the end of the COVID-19 public health emergency?

A 11.1: On March 16, 2020, the Centers for Medicare and Medicaid Services (CMS) provided guidance to the Department of Medical Assistance Services (DMAS) that no Medicaid individuals are to experience a closure in their case due to the current state of emergency due to COVID-19. In addition, DMAS and the Virginia Department of Social Services implemented system changes to prevent automatic disenrollment for certain groups of Medicaid-eligible individuals due to life events, such as attaining a maximum

age for certain covered groups or having reached the end of the two month post-partum period for pregnant women. Unfortunately, due to the timing of these events, some Medicaid individuals experienced disenrollment from their existing enrollment, either reducing or ending their Medicaid benefits starting April 1, 2020.

DMAS is currently working to reinstate all of these enrollments that were closed effective March 31, 2020. A mass re-enrollment process will occur prior to the normal cut-off date, April 16, 2020, for these individuals. This re-enrollment will retroactively reinstate coverage starting April 1, 2020 and going forward and will re-enroll these individuals in their previous managed care health plan. DMAS is committed to ensuring that providers rendering services for the impacted members will be reimbursed for the members with an existing, open service authorization. Please continue to provide the same level of service that you previously had been for these individuals. Information regarding these closures and re-enrollments is being sent in a letter to the affected individuals. If one of your clients has been affected by a closure during this state of emergency, you may view the provider portal periodically to check that the individual is reinstated.

It is still possible for manual closures to occur, although these numbers should be small. DMAS teams will be monitoring any closures each week and will re-enroll individuals who have been erroneously removed from coverage through the end of the emergency. DMAS will also continue to communicate with local DSS agencies to give clear direction throughout the emergency. If you or one of your clients receives notification of an individual's eligibility being terminated during this state of emergency, please have the affected individual contact his or her local department of social services. Please be aware that once this public health emergency has ended, individuals may experience a change in their Medicaid coverage based on program requirements.