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)

MEMO: Special

DATE: 7/15/2020

SUBJECT: COVID-19 Policy Continuation and Timeline

This memo sets out guidance from the Department of Medical Assistance Services (DMAS) on requests that have been made to extend federal and state authorities that allow regulatory flexibilities to providers during the public health emergency presented by the COVID-19 (novel coronavirus), as well as end-dates of certain flexibilities. (Note that this memo does not cover Home and Community Based Waiver services; these are discussed in a memo dated June 26, 2020.)

This memo is an update on certain flexibilities and as more information is received, DMAS will provide additional updates. Providers are encouraged to frequently access the DMAS website to check the central COVID-19 response page for both frequently asked questions (FAQs) and guidance regarding these flexibilities. For additional questions about this memo or other COVID-19 related issues, the agency has created a centralized point of access for submission at http://dmas.virginia.gov/contactforms/#/general. Questions may also be submitted to COVID-19@dmas.virginia.gov.

Background on Authorities

Certain flexibilities are permitted to be in effect only during the federal public health emergency. DMAS has received guidance that the federal public health emergency is very likely to be extended for 90 days until October 22, 2020. At the state level, Virginia Executive Orders (EO) 51 and 58 provide corresponding policy flexibilities tied to the state public health emergency declaration, which currently does not have an expiration date.

Most flexibilities depend on both state and federal law. DMAS is required to unwind the flexibilities it obtained when either the federal or the state emergency period expires.

The purpose of this memo is to provide an update for certain COVID-19 flexibilities.

Nursing Facilities:
DMAS will continue to extend the following flexibilities until October 22, 2020.

1. The additional payment of $20 per person per day.

2. Suspend Pre-Admission Screening and Annual Resident Review (PASARR) Level I and Level II Assessments for 30 days.

3. Extend minimum data set authorizations for nursing facility and skilled nursing facility (SNF) residents.

4. Waive 42 CFR 483.20(k) allowing nursing homes to admit new residents who have not reached Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness or intellectual disability should be referred promptly by the nursing home to state PASARR program for Level 2 Resident Review.

5. Waive the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d).

Home Health and Hospice:
DMAS will extend the following flexibilities until October 22, 2020.

1. Waive the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks to evaluate if home health aides are providing care consistent with the care plan.

2. Suspend the 2-week aide supervision by a registered nurse or licensed therapist for home health agencies. In lieu of a face-to-face supervisory visit, the nurse or licensed therapist may conduct the supervisory visit by telephone or via video communication. The nurse is required to contact the home health aide or the member/caregiver to set up the supervisory visit.

3. Waive the requirements at 42 CFR §418.76(h), which require a nurse to conduct an onsite supervisory visit every two weeks to evaluate if hospice aides are providing care consistent with the care plan. In lieu of a face-to-face supervisory visit, the registered nurse may contact the individual by telephone or via video communication. The nurse is required to contact the home health aide or the member/caregiver to schedule the supervisory visit.

Durable Medical Equipment:

DMAS will extend the following flexibilities until October 22, 2020.

1. DMAS will allow National Coalition for Assistive and Rehab Technology (NCART) recommendations for remote protocol, for complex rehab equipment, which allow only one

member of the evaluation team meet face-to-face with the member for evaluations. The evaluation team should include a licensed therapist and an ATP.

2. DMAS will allow the use of telehealth visits for therapy evaluations unless it is determined a face-to-face evaluation is warranted. The therapist performing the evaluation must be able to determine the appropriate durable medical equipment via telehealth.

3. DMAS is temporarily waiving the face-to-face requirement for durable medical equipment for the list of codes published by Medicare and listed in the Durable Medical Equipment and Supplies Manual, Chapter IV.

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

- Members who are being discharged home to clear hospital beds in preparation of the hospital overflow issues. A written, faxed or verbal order from the practitioner is required for short-term oxygen to include diagnosis, flow rate and length of need.

- Members who are being treated at home to prevent a hospital admission. A written, faxed or verbal order from the practitioner is required for short-term oxygen to include diagnosis, flow rate and length of need.

5. Certificate of Medical Necessity (CMN)

- Current CMNs: DMAS will allow a temporary extension of current CMNs until the end of the state of emergency. This will extend a current CMN from the end of the normal CMN validity time frame to the end of the state of emergency. This action should decrease the documentation burden on providers and practitioners. The DME provider can use the temporary extension to request an extended service authorization if required.

- For new orders: DMAS will allow a temporary suspension of the requirement for a CMN for new orders. The suspension of CMN requirement for new orders will be in effect starting April 13, 2020 and will end at the end of the state of emergency.
  - The DME provider must have a written, faxed, emailed or verbal order from the practitioner that includes the members name, item(s) is being ordered and a diagnosis.

  - Verbal orders must be documented in the member's record with the name of the ordering practitioner, date and time of the call and name of staff accepting the order. If the verbal order is given by a member of the practitioner's staff on behalf of the ordering practitioner, the DME provider must also document the name of the caller giving the verbal order on behalf of the ordering practitioner.

  - For disposable supplies: The DME provider must document, in the member's chart, quantity and frequency of use if it is not included on the order. This can be obtained via fax or email from the practitioner's office.

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

Pharmacy:

DMAS will extend the following flexibility until the end of the federal public health emergency declaration (October 22, 2020).

1. Suspend all drug co-payments for Medicaid, FAMIS, and FAMIS Moms members.

2. Coverage for a 90-day supply for all drugs excluding Schedule II drugs.

3. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Service Authorization:
DMAS will extend the following flexibilities until August 31, 2020.

1. DMAS suspended service authorization for certain home health, DME and computed tomography scans. Please see Attachment B to the March 19, 2020 memo for a list of the services and items for which authorization is being extended.

2. Extending prior authorizations that members have already received through the end of the public health emergency.

Provider Enrollment:
DMAS will extend the following flexibilities until August 31, 2020.

1. Provider Enrollment and Screening requirements listed below do not affect provider and licensing requirements established by the Department of Health Professions, the Department of Health, or the Department of Behavioral Health and Developmental Services – those requirements remain in place. MCOs will adhere to any changes that will not directly change their current contractual obligations with DMAS.

- Waive provider application fees.
- Waive criminal background checks for providers of adult services for individuals over the age of 18.
- Waive site visits conducted prior to enrolling a provider.
- Postpone deadlines for revalidation of providers.
- Waive conditions of participation or conditions for coverage for existing providers for facilities for providing services in alternative settings, including using an unlicensed facility, if the provider's licensed facility has been evacuated.

2. Waive requirements that physicians and other health care (including behavioral healthcare) professionals be licensed in Virginia in order to provide services to Virginia residents, so long as they have equivalent licensure in another state.

3. Allow Medicaid enrollment of out-of-state licensed providers.

Fair Hearings/Appeals

The following appeal flexibilities will be extended until the end of the federal public health emergency on October 22, 2020:

1. An extension for the timeframe to file client appeals. During the emergency, Medicaid/FAMIS applicants and members in DMAS fee-for-service were afforded greater than 30 days from the adverse action to file the appeal and members enrolled in a Medicaid Managed Care Organization ("MCO") were afforded greater than 120 days from the MCO's internal appeal decision to file an appeal with DMAS. The 30-day timeframe for applicants and fee-for-service members, as well as the 120 day timeline for MCO members, will apply again at the conclusion of the federal public health emergency.

2. A shortened timeframe for MCOs to issue an internal appeal decision in non-expedited client appeals. During the emergency, DMAS MCOs were required to issue an internal appeal decision within 14 days of receipt of the appeal request in non-expedited cases. At the conclusion of the federal public health emergency, the MCO will have up to 30 days (or with the extensions permitted under federal regulation) to issue internal appeal decisions in non-expedited cases.

3. Delays in scheduling client appeal hearings and issuing client appeal decisions. CMS concurred that the public health emergency related to COVID-19 warranted the use of the exception described in regulation to delay taking final administrative action, which included scheduling of fair hearings and issuing fair hearing decisions due to an emergency beyond the state's control. (42 CFR 431.244(f)(4)(i)(B)). DMAS will add the applicable delay for the appeals in process during the period of emergency. Additionally, appeals received after the end of the federal public health emergency will be processed by DMAS in accordance with the federal timeframes.

4. Verbal authorization for representation during the appeal. During the public health emergency, the federal government suspended the requirement for written authorization and allowed an appellant to designate a representative through verbal authorization. At the conclusion of the federal public health emergency, DMAS will only permit authorization that has been obtained in writing.

The following appeal flexibilities were based exclusively on the authority provided by Governor Northam's Executive Order 51 and will be extended until the end of the Executive Order:

1. Automatically continuing coverage during client appeals when the action involved a denial, reduction, or termination of existing eligibility or services. During the emergency, the coverage was automatically continued by the MCO during the internal appeal and by DMAS during the State Fair Hearing, with no financial impact to the member. At the conclusion of the period of the Executive Order, individuals filing appeals will be required to make a request for continued coverage during the required time period. The member may also be financially responsible if they do not prevail in the appeal.

2. Automatically grant client appeal reschedule requests and schedule a new hearing when the appellant misses a scheduled hearing. During the emergency, the hearings were automatically rescheduled at the appellant's request or if the appellant missed a hearing. At the conclusion of the period of the Executive Order, if an appellant misses a hearing, it will only be rescheduled for good cause. Additionally, under 12 VAC 30-110-230, a hearing will only be rescheduled twice unless compelling reasons exist.

3. Conduct all hearings via telephone. Due to the nature of COVID-19, DMAS suspended all in-person hearings during the period of the Executive Order. If elected by a provider or client, DMAS will conduct face-to-face appeal hearings as long as the hearing can safely be held, possibly including measures such as social distancing and the use of personal protective equipment.

4. Extension of the deadline to file a provider appeal. DMAS permitted providers to request an extension to the timeframe to file a provider appeal. No further extension requests will be granted at the conclusion of the Executive Order.

5. Extension of other provider appeal timeframes. Using the authority granted in the Executive Order, the provider appeal regulatory deadlines were extended for a period equal to the length of the total duration of the emergency, unless specific deadlines were set by the Informal Appeals Agent or Hearing Officer. At the conclusion of the period of the Executive Order, any new appeals filed will be processed under the standard appeal timelines.

Eligibility and Enrollment:

With the announcement of the extension of the federal public health declaration, continuity of coverage must remain until October 22, 2020 for Medicaid members, and no adverse action will be taken on Medicaid cases through that date.

CMS guidance has been received indicating that the continuity of coverage does not apply to CHIPRA 214 (Lawfully Residing Pregnant Women and Children Under), CHIP (FAMIS MOMS) whose post-partum period has ended, and CHIP (FAMIS) children turning 19. Individuals who have reached age 19 or who have reached the end of their pregnancy period who are enrolled in CHIPRA 214 or CHIP coverage groups will be re-determined and enrolled in other coverage or, if no longer eligible, referred to Marketplace coverage and closed.

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PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov

Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or Call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	www.aetnabetterhealth.com/Virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-800-901-0020
Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166
United Healthcare	www.Uhccommunityplan.com/VA and www.myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711),