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MEDICAID MEMO

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

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

DATE: 5/15/2020

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

This memo is the fifth in a series that sets out the Agency's guidance on the flexibilities available to providers in light of the public health emergency presented by the COVID-19 virus. The flexibilities in this memo include specific items related to Home and Community-Based Services (HCBS) Waivers, including the DD Waivers and the CCC Plus Waiver. These flexibilities are relevant to the delivery of covered services for COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact.

Please note that the policy changes set out in this memo are in effect during the public crisis, as set out in the Governor's Emergency Declaration. This is a rapidly emerging situation and additional changes are forthcoming. Providers are encouraged to frequently access the Agency's 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.

Any flexibilities listed in the March 19, 2020 and April 22, 2020 Medicaid Memos are still in effect during this current state of emergency unless explicitly stated otherwise. At such time that these and other flexibilities and allowances cease, providers will be notified through a Medicaid Memo noting the effective dates of those actions.

Group Day Services

The Developmental Disabilities (DD) waivers' Group Day services are traditionally provided in a licensed, center-based environment and allow for intermittent community integration opportunities based on the recipient's Individual Support Plan. Due to the concerns inherent in delivery of day services in large groups and even in the larger community due to "stay at home" and social distancing guidance, Group Day services may be provided by and reimbursed to the authorized Day Support provider when provided in residential settings effective on or after 3/24/20, when the stay at home orders were issued.

Residential settings include licensed Group Home Residential, Sponsored Residential and Supported Living, as well as the private, unlicensed homes of individuals who receive Group Day services. Prior to providing the Group Day services in an alternative location, the provider must ensure that the individual agrees to receive the service in that location and that the residential setting agrees to both allow the provider access and the schedule of services. The Group Day service should not disrupt the lives of others in the residence nor unnecessarily intrude upon their privacy. These allowances are made given the parameters noted on the Department of Behavioral Health and Developmental Services (DBHDS) website http://www.dbhds.virginia.gov/covid19 in order to support individuals and ensure continuity of care. Providers must adhere to the Licensing requirements before considering delivery of these services and subsequent reimbursement.

Community Engagement/Community Coaching

The DD waivers services of Community Engagement (CE) and Community Coaching (CC) are licensed community-based day services. DMAS, in concert with the DBHDS Office of Licensing, is allowing these services to be provided and reimbursed in the individual's homes. The home settings include licensed settings delivering Group Home Residential, Sponsored Residential and Supported Living as well as the private, unlicensed home of the individual. These services may be delivered via telehealth during the emergency for those individuals who were authorized for these services effective on or before 3/12/20. This allowance is only permitted for those authorizations in effect *prior* to 3/12/20. Telehealth services as described above will not be allowed for services authorized after that effective date.

The telehealth service may be provided for individuals who have the technological resources and ability to participate with remote CE/CC staff via virtual platforms (e.g., ZOOM, UberConference, etc.) in order to build computer skills to connect them with other community members. Some examples of the use of telehealth technology for the delivery of these services might be:

- Distributing garden kits to DD waiver individuals to start in their home and linking them to garden experts for weekly online meeting and instruction.
- Partnering with a retirement facility and connecting DD waiver individuals to a friend in the retirement facility for weekly conversations about daily living, special interests/hobbies, exercising together through videos/video games, or participating in online board games.
- Completing career exploration online such as career scope assessments, reviewing interview skills, and participating in teleconference discussion with community members in fields of career interest.
- Coordinating with volunteer agencies to collect and distribute take home volunteer projects such as assembling care packages with online training/instruction from staff, as well as connecting individuals virtually to other volunteers to such discuss projects.
- Conversing with others about recent events as we all live this shared experience.

The above examples would comport with these service's allowable activities of:

- Improving social and communication skills
- Building and maintaining friendships
- Expanding social networks
- Enhancing career readiness skills

- Participating in volunteer activities
- Promoting health and wellness

In all of these examples, a CE or CC staff member would be expected to guide individuals through IT support, the development of online social skills, building relationship bridges through social exchanges, coordinating planning of resources and supplies, etc. The CE or CC provider would be expected to ensure that the individual agrees to receive the service(s) in that location and that the residential setting agrees to both allow the provider access and the schedule of services. The Group Day service should not disrupt the lives of others in the residence nor unnecessarily intrude upon their privacy.

In-home Support Services

Currently, DD waiver In-home Support services are provided generally on a 1:1 basis with individuals in their home environment. The individuals receiving these services live independently, with roommates or with their families. DMAS, in concert with the DBHDS Office of Licensing, is allowing 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 allows services to continue to be provided remotely in the home setting in order to support individuals in remaining independent and ensure continuity of care, as well as increasing monitoring of vulnerable individuals' health and safety during a heightened period of isolation due to the COVID-19 crisis. This allowance is only permitted for those authorizations in affect prior to the emergency declaration on March 12, 2020. Telehealth services as described above will not be allowed for services authorized after that effective date.

Service Authorization Implications

Group Day: For an individual receiving Group Day services from the same provider as he did prior to the pandemic but now in the residential setting, modifications needed to the Plan for Supports (e.g., different support activities to be delivered, altered schedule, etc.), should be made; however, those changes will likely not necessitate a service modification request via WaMS. Service documentation should indicate the location of service delivery.

For situations in which the individual will be receiving Group Day services from a different provider, who is licensed and enrolled as a Group Day provider, than he did prior to the pandemic, a service modification to include a new Plan for Supports detailing those services and schedule will need to be submitted via WaMS. This service authorization request must include:

- an attestation from the Support Coordinator in the notes section of the request in WaMS that he/she has verified the individual's choice of new provider; and
- understanding of this on the part of the original Group Day provider.
- Additionally, there must be an attestation from the original Group Day provider agency, that they are unable or unwilling to serve the individual and that they will be **forfeiting access to retainer payments** noted in the next section.

As mentioned in the April 22, 2020 Medicaid Memo, it is not necessary for the original provider to terminate service authorization at this time, even if the "combined hours" exceed the 66-hour per week limit. However, the original provider may not bill for these services. Authorizations for new Group Day services providers delivering supports in the home will be allowed only from

March 24, 2020 and forward. At the end of the emergency period, when Group Day services are no longer provided in the home, the authorization of one of the two providers shall be terminated via the Support Coordinator in WaMS.

Community Engagement/Community Coaching and In-home Supports: For situations in which any of these services are delivered via telehealth to individuals in their homes, a new Plan for Supports reflecting the new activities, the accompanying schedule, and a detailed method of service delivery must be submitted for service authorization via WaMS. In all situations, the Plans for Supports must reflect those allowable activities that are conducted. Additionally, documentation must reflect these new activities and the service delivery method, as well as the individual's willingness and ability to participate in telehealth supports and services.

In-home Supports: Additional documentation in the record and changes to the Plan for Supports will be required in order to deliver the services via telehealth. The Plan for Supports must be updated to reflect those allowable activities that will be conducted *specific* to telehealth delivery and submitted with a request for service authorization. Additionally, documentation must indicate which activities were delivered via telehealth, as well as the individual's willingness and ability to participate in telehealth supports and services.

Retainer Payments

Retainer payments may be provided for circumstances in which providers have experienced significant decline in service utilization due to COVID-19 containment efforts because the waiver participant is sick due to COVID-19 or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders (to include the Governor's stay at home order).

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.

To bill the retainer payments, the provider must use the existing procedure code for the service authorized and add the modifier "CR." For the retainer payment, providers may claim up to the number of units that are currently authorized, billed at the retainer rate. For those members that might have an assigned patient pay, that patient pay will not be assessed on claims utilizing the CR modifier for the retainer payment and should not be included in the claim. If however, there are services delivered, the usual process should be followed.

The table below (Table 1) delineates the services by procedure code with the retainer rates noted as a result of the 65% reduction. Due to the nature of the DD Waiver customized rates for Community Coaching and Group Day Services, these rates are not included below but when billed by the provider with the CR modifier, the rate will automatically reduce by 65%.

Table 1:

Retainer Rates (CR Modifier)			
Service	Proc code	Retainer Rate	
		ROS	NOVA
Adult Day Health Care	S5102 CR	$37.08	$40.04
Group Day Services Tier 1	97150 CR	$5.59	$6.51
Group Day Services Tier 2	97150 CR	$7.31	$8.53
Group Day Services Tier 3	97150 CR	$8.65	$10.11
Group Day Services Tier 4	97150 CR	$11.27	$13.19
Community Engagement Tier 1	T2021 CR	$9.29	$10.52
Community Engagement Tier 2	T2021 CR	$10.41	$11.84
Community Engagement Tier 3	T2021 CR	$11.95	$13.66
Community Engagement Tier 4	T2021 CR	$14.70	$16.89
Community Coaching	T2013 CR	$19.01	$21.79

Retainer payments may be billed retroactively to March 12, 2020 and are effective through June 30, 2020. Per CMS guidelines, retainer payments may not exceed 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 30th, April 17th, May 5th, May 22nd, June 9th, and June 29th (Table 2).

Table 2:

No Retainer Payment Billing Dates	
March 30, 2020	May 22, 2020
April 17, 2020	June 9, 2020
May 5, 2020	June 29, 2020

Adult Day Health Services

Managed Care Organizations (MCOs) will make ADHC provider retainer payments in accordance to the rules and processes set out in this memo. In order to receive retainer payments from the MCOs, ADHC providers must submit claims to the applicable MCO with the modifier "CR." All MCOs will accept and process claims with the modifier "CR" beginning May 22, 2020 with exception of Magellan Complete Care, which will accept and process claims with the modifier "CR" beginning May 27, 2020.

Retainer payments are available to ADHC providers for members with active service authorizations on March 12, 2020. In the event that the authorization has expired since March 12, 2020, ADHC providers should submit a service authorization request to the appropriate MCO or FFS entity for the same level of service that was active on March 12, 2020. The authorization request will be honored retroactive to the date of the original authorization expiration.

Group Day, Community Engagement, Community Coaching
There may be instances when providers are able to provide some limited services for individuals but unable to provide the same level of service experienced prior to the emergency. In this case, the provider would bill for services that were actively provided at the regular rate without the modifier. The remaining balance of the service authorization may be billed with the retainer payment modifier (CR).

Example Group Day Service (97150):
Current authorization: 40 hours per week
Active services being provided: 10 hours per week
Bill: 10 hours- current rate (97150)
Bill: 30 hours with CR modifier (97150-CR). DMAS will automatically reimburse at 65% of the rate.

It is important to note that if the individual has chosen to receive services from another day service provider during the emergency, the original provider will forfeit their ability to bill for retainer payments (See Service Authorization Implications above).

Retainer payments are available to DD Waiver Group Day, Community Engagement, Community Coaching providers for members with active service authorizations on March 12, 2020. In the event that the authorization has expired since March 12, 2020, providers should submit a service authorization request to WaMS for the same level of service that was active on March 12, 2020. The authorization request will be honored retroactive to the date of the original authorization expiration.

Appeals

Due to a concern expressed by the Health Districts about staffing as they address the COVID-19 public health emergency, the DMAS Appeals Division is adjusting the procedures for rescheduling pre-admission screening hearings during the COVID-19 emergency. If an appellant misses the initial scheduled hearing, DMAS will reschedule the hearing. The Appeals Division will contact the appellant by phone to confirm attendance for the rescheduled date. If there is no response by the appellant, the appeal will remain open, but the hearing will be removed from the calendar. In those instances, DMAS will schedule a new hearing date after the public health emergency is over.

CCC Plus Waiver – April 22, 2020 Memo Clarification

Waiver individuals who receive fewer than one service per month will not be discharged from a HCBS waiver. Waiver individuals shall receive monthly monitoring when services are furnished on a less than monthly basis. Monthly monitoring may be in the form of telehealth visits including phone calls. **Monthly monitoring shall be performed by the CCC Plus managed care plan, or DMAS for fee-for-service (FFS), when the member does not receive a waiver service monthly**. Providers are to inform each health plan when the member has elected to not receive services during this time. In order to inform the health plan about members choosing to not receive services, follow the instructions in the table 3 below.

Table 3:

Health Plan	Contact	Required Information
Aetna	Fax Number: 855-661-1828.	Member name, Medicaid ID, Date of Birth, and last date of service
Anthem	Fax Number: 844-471-7937 Please send a weekly list	Member name, Medicaid ID, Date of Birth, and last date of service
Magellan	Fax number (866-210-1523)	Member name, Medicaid ID, Date of Birth, and last date of service
Optima	fax number: 757-837-4702 or 844-828-0600	Member name, Medicaid ID, Date of Birth, and last date of service
United HealthCare	*E-Mail: va_cac@uhc.com Fax number: 844-842-6910	Member name, Medicaid ID, Date of Birth, and last date of service
Virginia Premier	*E-Mail: VPHPCLINREVTEAM@virginiapremier.com Fax number: 877-794-7954	Member name, Medicaid ID, Date of Birth, and last date of service
DMAS- FFS	*Email: CCCPlusWaiver@dmas.virginia.gov Send an email to the address to request a secure email if encryption is not available.	Member name, Medicaid ID, Date of Birth, last date of service, and contact phone number
*E-Mail is the preferred method. All e-mails must be sent via a secured, encrypted method in order to protect PHI. If encryption is not available, please send via the alternate Fax number.		

ADDITIONAL INFORMATION ON THE MEDICAID WAIVERS:

DBHDS website:
http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community

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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),