The following flexibilities expire 06/30/2021 and enforcement is effective 60 days post expiration.

Flexibility	State Regulation
Nursing Facilities	
Waive 42 CFR 483.20(k) and § 32.1-330 allowing nursing homes to admit new residents who have not reached Level 1 or Level 2 Preadmission Screening.	12 VAC 30-60-302(A)-(B) 12 VAC 30-130-150(A)-(B), (E) § 32.1-330 12 VAC 30-10-520(E) 12 VAC 30-60-302
Extend minimum data set authorizations for nursing facility and skilled nursing facility (SNF) residents.	VA Code 32.1-330. 12 VAC 30-60-302. 12VAC30-130-140 through 12VAC30-130-260 (04/01 Update)
Community-based and hospital LTSS Screeners may continue to accept verbal consent on the Individual Choice Form, DMAS-97 verified by two witnesses	§ 32.1-330
Community-Based Teams may continue to conduct LTSS Screenings using telehealth methods. Community screenings must be completed within 30 days of the initial request.	§ 32.1-330 12 VAC 30-60-301, 302, 304
Pharmacy	
Waive requirements for pharmacies to collect a signature upon delivery or 'proof of delivery' from patients to prevent the spread of the novel coronavirus through contamination of pens or electronic signature devices. For those circumstances where there is no patient's signature, the pharmacist shall write "COVID19," "COVID," or substantially similar language as the equivalent to receiving a signature.	Pharmacy Manual, Chapter 2
Home Health and Hospice	
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 VAC 30-50-270. Hospice Services (In Accordance with § 1905 (O) of the Act)
Waive the Home Health and Hospice requirements at 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.	12 VAC 30-50-160(C) 12 VAC 30-50-270(C)(5)(h)
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.	12 VAC 30-50-160(C) 12 VAC 30-50-270(C)(5)(h)

Flexibility	State Regulation
Home health agencies may perform certifications, initial assessments, and determines a patient's homebound status remotely by telephone or via video communication in lieu of a face-to-face visit.	12 VAC 30-60-70(D)(1-5)
Durable Medical Equipment (DME)	
DMAS will allow National Coalition for Assistive and Rehab Technology recommendations for remote protocol, for complex rehab equipment.	DME Manual
Waive the face-to-face requirement for durable medical equipment for the list of codes published by Medicare and listed in DME and Supplies Manual, Chapter IV.	12 VAC 30-60-75
Waive in person signature requirements for home delivery of DME supplies.	12VAC30-50-165(L)(1)
Due to industry concerns of supply chain disruptions, DMAS is instructing DME providers to only deliver one month of supplies at a time.	DME Manual
DME providers must have contact with the member/caregiver via email, text, messaging service, video, phone, etc. to validate the member's need for refill supply orders before delivering supplies.	12 VAC 30-60-75(D)
DMAS will waive in person signature requirements for home delivery of supplies until the end of the state of emergency. DME providers who are making home deliveries of supplies must be able to document delivery of supplies in lieu of an in person signature. Documentation of delivery can include a picture or text/email message from member/caregiver. If a third party carrier is used for delivery of supplies the DME provider must continue to keep documentation of confirmed shipment receipt as proof of delivery.	12 VAC 30-50-165
Fair Hearing/Appeals	
Suspend in-person client appeal hearings and in-person provider appeal informal fact-finding conferences.	12 VAC 30-110-230(B)
Automatically grant client appeal reschedule requests and automatically schedule a new hearing when the appellant misses a scheduled hearing (note: DMAS will grant reschedule requests if timely made and will allow the client/representative to submit good cause to show why a hearing was missed. A hearing will be rescheduled if good cause for missing the hearing is received in the timeframe set by the Hearing Officer).	12 VAC 30-110-230(B) 12 VAC 30-110-260
Waivers and Telehealth	

Flexibility	State Regulation
For services facilitation providers, the consumer (Individual) Training visit (S5109) and Services facilitation training (S5116) may be conducted using telehealth methods.	12VAC30-120-935 12VAC30-122-500
Waiver of face to face requirements for case management for LTSS DD waiver services.	12VAC30-50-410 through 12VAC30-50-440, 12VAC30-50-470 through 12VAC30-50-491
Allow personal care agencies and services facilitation providers to conduct visits through telehealth methods.	12VAC30-120-935 12VAC30-120-500 12VAC30-120-490 12VAC 30-120-460
Behavioral Health/ARTS	
Waiver of case management face-to-face requirements behavioral health and ARTS services. Face-to-face every 90 days may continue to be met via telehealth post the end of the state public health emergency per Executive Order 51 and 58.	12VAC30-50-410 through 12VAC30-50-440, 12VAC30-50-470 through 12VAC30-50-491
Waiver of certain discharge requirements for behavioral health 1) if an individual is ready for a lower level of care and 2) waive the discharge requirement if there are no services for 30 days.	12VAC30-60-61-C(14) 12VAC30-60-61-D(17) 12 VAC 30-50-130(D)(2)(c)(4) and (D)(2)(g)(4)
Service Authorizations for Behavioral Health and ARTS A 14-day grace period will be granted for the submission of Behavioral Health Authorizations within Community Mental Health Rehabilitation Services (CMHRS), Assessments, Psychotherapies, Inpatient Treatment Services, and ARTS Levels of Care: • Medicaid managed care organizations (MCOs) and Magellan of Virginia will allow up to 14 days after the start of a new behavioral health or ARTS service or after the expiration of an existing authorization for a service authorization request to be submitted from the provider to the MCO or Magellan of Virginia. • This grace period does not waive medical necessity requirements for the services or other requirements currently set forth in policies for submissions of service authorization requests. • This grace period does not guarantee payment.	MCO/BHSA Contracts
Policy flexibilities for behavioral health services – Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill Building (MHSS), and Psychosocial Rehabilitation (PSR).	12VAC30-60-61 12VAC30-50-226

Flexibility	State Regulation
Service delivery may be provided outside of the school setting, office setting, or clinic setting for the duration of the PHE.	
Policy flexibilities for behavioral health services – TDT providers licensed for school-based and non-school based care may provide services outside of the school, including during the summer, with their current license due to current needs to maintain social distancing. Providers are reminded that they must report to DBHDS Office of Licensing any changes to their programs that have occurred as a result of COVID-19.	12VAC30-60-61
Policy flexibilities for behavioral health services – 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.	12 VAC 30-50-130(D)(2)(c)(4) and (D)(2)(g)(4) 12 VAC 30-60-61(C)(14), (D)(17)
Behavioral Therapy – • For Behavior Therapy services, a physician letter, referral, or determination is not required for submission of a service authorization. The MCO and Magellan of Virginia shall review the request and make a determination without the physician referral. The physician referral, letter or determination shall be completed within at least 60 days of the start of the service	12VAC30-60-61
Independent Assessment Certification and Coordination Team (IACCT) • IACCT Assessments may be completed by out-of-network providers, but these individuals must be an independent evaluator separate from the residential facility. IACCT Assessments completed by an out-of-network provider must be coordinated with Magellan of Virginia.	12VAC30-50-130(D)
Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care • For members in psychiatric inpatient, facility based crisis stabilization, PRTF and TGH, medical necessity for continuation of care may be waived if the individual is unable to transition to lower levels of care due to COVID-19 and quarantines. Providers who are requesting service authorization for members who are unable to discharge due to barriers related to COVID-19, are asked to answer the following questions when	12VAC30-50-130(D) 12VAC30-50-100(F) 12VAC30-50-226(B)(5)

Flexibility	State Regulation
requesting an authorization. Providers shall submit an additional page with the information when submitting the request online or be prepared to answer the questions during phone reviews. 1. What are the barriers to discharge related to COVID-19? 2. Please describe attempts to overcome these barriers since the last Service Request Authorization was submitted. 3. What are the restrictions and/or limitations for step-down to the identified discharge disposition? 4. What aftercare services are available in their community during this pandemic? 5. What agencies has this individual been referred to? 6. How will the treatment plan and goals be adjusted to sustain current progress and prevent regression? Answering all these questions when requesting authorization will expedite the review process. The answers to these questions are required each time you are requesting continued stay for a member who has not discharged due to barriers related to COVID-19. • If an individual currently in a PRTF or TGH requires acute or inpatient medical treatment (non-psychiatric) for more than seven days for PRTF and ten days for TGH, the authorization will NOT be ended and the individual does not have to be discharged from the PRTF or TGH. For any subsequent admission to a PRTF or TGH, the previous admission shall be extended. The provider shall not bill for the time where the individual is admitted into acute care. • Providers should refer to guidance from the CDC regarding best practices for facilities. • If members are in need of quarantine because they are ill, the provider should coordinate their efforts with their department of health. More information can also be found on the VDH webpage. • If individuals are in need of quarantine and hospitals are attempting to step them down to a psychiatric unit or facility, we would encourage providers and clinicians to evaluate the appropriateness of this transfer or step down. • Service authorization requirements and medical necessity criteria will have to be met for admission into this level of care.	

Flexibility	State Regulation
ARTS IOP and PHP – If providers are unable to provide the minimum amount of services required for the reimbursement of PHP/IOP, providers may bill the most appropriate psychotherapy, assessment, and evaluation codes.	7/22/2020 Medicaid Memo
ARTS IOP and PHP – During the PHE, if CSACs or CSAC-Supervisees are performing substance use disorder (SUD) counseling within their scope of practice, DMAS will waive the requirement for only licensed practitioners to bill the psychotherapy codes. CSACs and CSAC-Supervisees will be allowed to bill using the most appropriate psychotherapy code based on the amount of time spent performing the service, bill under their licensed supervisor NPI and document the reason for billing the psychotherapy code by the CSAC or CSAC-Supervisee is due to not meeting the minimum time for billing the per diem.	12VAC30-130-5090 12VAC30-130-5100 Va. Code 54.1-3507.1
DMAS also recognizes that members may not be able to pick up their medications from OTPs during this PHE. Thus, DMAS will allow OTP providers to deliver the medications to the member's location and be reimbursed for this service. For delivery of up to a two week supply of medications: Bill 5 units of H0020 at $8.00/unit (equates to $40.00 or 70 miles round trip applying the federal personal mileage rate of 57.5 cents per mile). For delivery of three weeks or greater supply of medications: Bill 10 units of H0020 at $8.00/unit (equates to $80.00 or 140 miles round trip).	12VAC30-130-5050(12)
If an individual currently in a PRTF or TGH requires acute or inpatient medical treatment (non-psychiatric) for more than seven days for PRTF and ten days for TGH, the authorization will NOT be ended and the individual does not have to be discharged from the PRTF or TGH. For any subsequent admission to a PRTF or TGH, the previous admission shall be extended. The provider shall not bill for the time where the individual is admitted into acute care.	12VAC30-50-130