The following flexibilities expire 06/30/2021:

Flexibility	State Regulation
General or Applies to Multiple Services	
Waiver of public notice requirements that would otherwise be applicable to state plan amendment submission.	
Nursing Facilities	
Suspend Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II Assessments for 30 days.	§ 32.1-330. 12 VAC 30-10-520(E) 12 VAC 30-60-302
For admissions occurring after March 12, 2020, nursing facilities do not need to obtain Medicaid LTSS Screening packages that would normally be required by 12VAC30-60-308, and may admit individuals without the Medicaid LTSS screening package. The individual may be admitted directly to the nursing facility without a LTSS Screening.	§ 32.1-330. Long-term services and supports screening required Items C,E,F
Durable Medical Equipment (DME)	
Allow a temporary extension of current Certificate of Medical Need (CMN) and allow a temporary suspension of the requirement for a CMN for new DME orders. (See footnote)	12 VAC 30-60-75 § 32.1-325(A)(14)

Footnote – For DME flexibility related to CMNs:

The DME flexibility for CMNs will end on 6/30/21. Providers will need to get a new CMN for any item in which the current CMN, verbal order or written order will end with the end of the state of emergency (6/30/21). As a reminder, DME providers have 60 days to have a new CMN signed and dated by the ordering practitioner to cover dates of service back to the begin service date on the CMN. So for example, if the begin service date on the new CMN is 7/1/2021, the provider will need to have the CMN signed and dated by 8/29/2021. If the DME provider has a current CMN that covers dates of services beyond 6/30/2021, a new CMN is not required until the current CMN expires. A new CMN is not required for every order only those that used a CMN extension, verbal order, faxed order or written order, in place of a new CMN, during the pandemic.

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
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
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). Service delivery may be provided outside of the school setting, office setting, or clinic setting for the duration of the PHE.	12VAC30-60-61 12VAC30-50-226
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	12VAC30-60-61

Flexibility	State Regulation
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.	
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

The following flexibilities remain active at this time:

#	Flexibility	Status
General or Applies to Multiple Services		
1.	Suspend all drug co-payments for Medicaid and FAMIS members.	Active
2.	Telehealth policies – as described in prior Medicaid Memoranda issued on March 19, 2020, May 15, 2020, and September 30, 2020 – including waiver of penalties for HIPAA non-compliance and other privacy requirements.	Active
3.	Allow facilities to be fully reimbursed for services rendered to an unlicensed facility (during PHE). *This rule applies to facility based providers only.*	Active
4.	Electronic signatures will be accepted for visits that are conducted through telehealth.	Active
Waivers		
5.	Members who receive less than one service per month will not be discharged from a HCBS waiver.	Active
6.	Any member with a significant change requesting an increase in support due to changes in medical condition and/or changes in natural supports must have an in-person visit.	Active
7.	Allow legally responsible individuals (parents of children under age 18 and spouses) to provide personal care/personal assistance services for reimbursement.	Active
8.	Personal care, respite, and companion aides hired by an agency shall be permitted to provide services prior to receiving the standard 40-hour training.	Active
9.	Allow Community Engagement (CE)/Community Coaching (CC) to be provided through telephonic/video-conferencing for individuals who have the technological resources and ability to participate with remote CE/CC staff via virtual platforms,	Active
10.	Allow In-home Support services to be delivered via an electronic method or telehealth of service delivery.	Active
11.	Allow Group Day Services to be provided through video conferencing for individuals who have the technological resources and ability to participate with remote Group Day staff via virtual platforms.	Active
12.	Residential providers are permitted to not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time.	Active
Addiction & Recovery Treatment Services (ARTS)		
13.	Opioid treatment programs may administer medication as take home dosages, up to a 28-day supply.	Active
14.	Allowing a member's home to serve as the originating site for prescription of buprenorphine.	Active
Behavioral Health Services		
15.	Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill Building (MHSS), Intensive Community Treatment (ICT) and Psychosocial Rehabilitation (PSR). • The service authorization request for new services will be used to track which members are continuing to receive these services, assess the appropriateness of the services being delivered via different	Active, telehealth

	modes of treatment, and to determine if this is an appropriate service to meet the member's needs.	
16.	Therapeutic Day Treatment (TDT), Intensive In-Home Services (IIH), Mental Health Skill Building (MHSS), Intensive Community Treatment (ICT) and Psychosocial Rehabilitation (PSR). • Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHPRP, LMHP-S, QMHP-A, QMHP-C, or QMHP-E and the individual.	Active, telehealth
17.	For youth participating in both TDT and IIH, TDT should not be used in person in the home as this would be a duplication of services. TDT may be provided through telehealth to youth receiving IIH (in person or via telehealth) as long as services are coordinated to avoid duplication and ensure efficacy of the treatment provided.	Active, telehealth
18.	During the PHE, TDT, IIH, MHSS, ICT and PSR providers may bill for one unit on days when a billable service is provided, even if time spent in billable activities does not reach the time requirements to bill a service unit. This allowance only applies to the first service unit and does not apply to additional time spent in billable activities after the time requirements for the first service unit is reached. Providers shall bill for a maximum of one unit per day if any of the following apply: • The provider is only providing services through telephonic communications. If only providing services through telephonic communications, the provider shall bill a maximum of one unit per member per day, regardless of the amount of time of the phone call(s). • The provider is delivering services through telephonic communications, telehealth or face-to-face and does not reach a full unit of time spent in billable activities. • The provider is delivering services through any combination of telephonic communications, telehealth and in-person services and does not reach a full unit of time spent in billable activities.	Active, telehealth
19.	Behavioral Therapy (H2033) – • Face-to-face service requirements will continue to be waived, but documentation shall justify the rationale for the service through a different model of care until otherwise notified. The goals, objectives, and strategies of the ISP shall be updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual to COVID-19, as well as any newly identified problem. Documentation of this review shall be added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA or LABA.	Active, telehealth

20.	Behavioral Therapy (H2033) – • One service unit equals 15 minutes for this level of care. Effective June 11, 2020, Behavioral Therapy providers do not have a one unit max limit per day for audio-only communications	Active, telehealth
Nursing Facilities		
21.	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).	Active
Pharmacy		
22.	Drugs dispensed for 90 days will be subject to a 75% refill "too-soon" edit. Patients will only be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).	Active
23.	The agency makes exceptions to their published Preferred Drug List if drug shortages occur.	Active
24.	Suspend all drug co-payments for Medicaid and FAMIS members	Active
Appeals		
25.	For all appeals filed during the state of emergency, Medicaid members will automatically keep their coverage.	Active
26.	There will be no financial recovery for continued coverage for appeals filed during the period the emergency.	Active
27.	Delay scheduling of fair hearings and issuing fair hearing decisions due to an emergency beyond the state's control.	Active
28.	The state may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 CFR 431.230.	Active
29.	Allows applicants and beneficiaries to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals.	Active
30.	Modification of the timeframe under 42 C.F.R. §438.408(f)(2) for enrollees to exercise their appeal rights to allow more than 120 days to request a fair hearing when the initial 120th day deadline for an enrollee occurred during the period of this section 1135 waiver.	Active
31.	Verbal authorization for representation during the appeal.	Active
Member Eligibility and Enrollment		
Continuity of coverage will remain in place for Medicaid members through the end of the federal Public Health Emergency (PHE) and Maintenance of Effort (MOE). No closures or reduction of coverage will be taken on Medicaid enrollments through the end of the federally declared emergency unless a death is reported, an enrollee moves from Virginia permanently, or an enrollee requests closure of coverage. Individuals who become incarcerated must have their coverage reduced to cover inpatient services only. Federal continuity of coverage requirements do not apply to lawfully residing non-citizen pregnant women or children under age 19. Additionally, the continuity of coverage requirements do not apply for coverage in the Family Access to Medical Insurance Security (FAMIS) or FAMIS MOMS programs Individuals who no longer meet eligibility requirements in the FAMIS or FAMIS MOMS programs will be re-determined and enrolled in other coverage or, if no longer eligible, referred to the Federal Marketplace for coverage options. LTSS providers, please note that eligibility workers are unable to process increases in patient pay at this time due to the PHE and MOE.		

The following flexibilities previously expired and are no longer in place.

Flexibility	State Regulation	Expiration Date
General or Applies to Multiple Services		
Temporarily suspend Medicaid fee-for-service prior authorization requirements.	12 VAC 30-50-160(B) and (D) 12 VAC 30-50-165(B)(1)(a) and (9) 12 VAC 30-60-20(A)(1-3) 12 VAC 30-50-120 (B) 12 VAC 30-50-130 (C)(2)(a) 12 VAC 30-50-226 (B)(6)	3/05/2021
Temporarily suspend Medicaid Fee-for-Service and Managed Care Organization prior authorization requirements.	12 VAC 30-50-160(B) and (D) 12 VAC 30-50-165(B)(1)(a) and (9) 12 VAC 30-60-20(A)(1-3) 12 VAC 30-50-120 (B) 12 VAC 30-50-130 (C)(2)(a) 12 VAC 30-50-226 (B)(6)	8/31/2020
Pharmacy		
Virginia will suspend refill "too soon" edits for all drugs prescribed for 34 days or less.	12 VAC 30-50-210(A)(3)	8/20/2020
Durable Medical Equipment (DME)		
DMAS will allow temporary coverage for short-term oxygen use for acute conditions.		8/31/2020
Fair Hearing/Appeals		
A shortened timeframe for MCOs to issue an internal appeal decision in non-expedited client appeals.		3/05/2021
Providers affected by the COVID-19 emergency can request a hardship exemption to the normal deadline to file an appeal.	12 VAC 30-20-500	3/05/2021
Extension of provider appeal deadlines.	12 VAC 30-20-500	3/05/2021
Waivers and Telehealth		
In-person visits will be required for anyone newly enrolled in the waiver or in a waiver service must have an in-person visit with effective dates of May 1, 2021 or after.		5/01/2021
For members that have not had an in-person visit on or after 3/12/2020, the next required agency supervisory or services facilitator reassessment/routine visit should be done in person.		5/01/2021
Provider Enrollment		

Flexibility	State Regulation	Expiration Date
Waive provider screening requirements (payment of application fee; criminal background check; site-visit; in-state/territory licensure requirements) to permit provisional enrollment for: (1) Medicaid enrollment for a provider not already enrolled with Medicare or another State Medicaid Agency or Medicare (specific conditions apply); and (2) Medicare enrollment for a physician or non-physician practitioner.		8/31/2020
Postpone all revalidation actions of providers.		8/31/2020