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
21.	Crisis Stabilization/Crisis Intervention Services • The appropriateness of a crisis response using telehealth (including telephonic) shall be evaluated by the clinician and a determination shall be made by the clinician responding to the crisis. • Any therapeutic interventions to include, but not limited to, therapy, assessments, care coordination, team meetings, and treatment planning can occur via telehealth. • 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, if one is required, 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 and documented according to the requirements in the CMHRS Provider manual.	Active, telehealth
22.	Independent Assessment Certification and Coordination Team (IACCT) • Assessments IACCT Assessments may occur via telehealth or telephone communication.	Active, telehealth
23.	Psychiatric Inpatient, Facility Based Crisis Stabilization, Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Levels of Care • The requirement for service authorization remains in place. • Therapy, assessments, case management, team meetings, and treatment planning may occur via telehealth. The plan of care should be updated to include any change in service delivery as well as any change in goals, objectives, and strategies, including impacts on the individual due to COVID-19.	Active, telehealth
Nursing Facilities		
24.	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		
25.	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
26.	The agency makes exceptions to their published Preferred Drug List if drug shortages occur.	Active
27.	Suspend all drug co-payments for Medicaid and FAMIS members	Active
Appeals		
28.	For all appeals filed during the state of emergency, Medicaid members will automatically keep their coverage.	Active
29.	There will be no financial recovery for continued coverage for appeals filed during the period the emergency.	Active

30.	Delay scheduling of fair hearings and issuing fair hearing decisions due to an emergency beyond the state's control.	Active
31.	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
32.	Allows applicants and beneficiaries to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals.	Active
33.	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
34.	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.