REPORT OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Permanent Use of Virtual Supports Focused on Assistive Technology (AT)/Environmental Modifications (EM) Services (Chapter 224, 2021 SSI)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 27, 2021

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: Permanent Use of Virtual Supports Focused on Assistive Technology/Environmental Modification Services

This report is submitted in compliance with the Virginia Acts of the Assembly – Chapter 224 Enactment Clause 1, which states:

The Department of Medical Assistance Services shall establish a work group composed of individuals with developmental disabilities, families of individuals with developmental disabilities, representatives of advocacy organizations, and other appropriate stakeholders to study and develop recommendations for the permanent use of virtual supports and increasing access to virtual supports and services for individuals with intellectual and developmental disabilities by promoting access to assistive technology and environmental modifications. The Department shall report its findings and recommendations to the Governor and the General Assembly by November 1, 2021.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/alv
Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Permanent Use of Virtual Supports Focused on AT/EM Services

A Report to the Virginia General Assembly — *November 1, 2021*

Report Mandate:

Chapter 224 Enactment Clause 1 states:

The Department of Medical Assistance Services shall establish a work group composed of individuals with developmental disabilities, families of individuals with developmental disabilities, representatives of advocacy organizations, and other appropriate stakeholders to study and develop recommendations for the permanent use of virtual supports and increasing access to virtual supports and services for individuals with intellectual and developmental disabilities by promoting access to assistive technology and environmental modifications. The Department shall report its findings and recommendations to the Governor and the General Assembly by November 1, 2021.

Background

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constituted a national public health emergency. DMAS quickly responded to support the Commonwealth's Medicaid and CHIP enrollees on multiple fronts including, but not limited to: evaluating and seeking 1135 waiver authority to support the delivery of medical and behavioral health care services to Virginians during the crisis; developing a proposed approach to easing eligibility and enrollment and fair hearing processes; mitigating coverage delays; seeking amendments to DMAS' current waivers under Appendix K (Appendix I) to allow flexibilities in service delivery; and developing a Medicaid telehealth policy to ensure providers were equipped to serve Medicaid enrollees.

The Centers for Medicare and Medicaid (CMS) approved Virginia's Appendix K flexibilities which allowed for certain services to be delivered virtually through telehealth/telemedicine methods under the Home and Community-Based Services (HCBS) Waivers, including the Developmental Disability (DD) Waivers and the Commonwealth Coordinated Care (CCC) Plus Waiver.

COVID-19 significantly impacted Medicaid members who received home and community-based services. In order to manage their risk of COVID exposure, access to their regular caregivers or home and community-based treatment providers was significantly limited. As such, providers discovered ways to support individuals and families by providing the member's medically necessary services in their homes through the use of technology which also helped reduce the social isolation and anxiety experienced by many. These supports allowed individuals to continue to connect with their community in a safe manner.

While other delivery systems were able to shift virtually and utilize technology to maintain essential services and supports, the disability network faced difficulties

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 500,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

seeking effective virtual mechanisms. At times, this barrier has made it difficult to sustain continuity in care throughout the pandemic.

The public emergency created awareness on system-based deficits for access to technology via the Assistive Technology (AT). Individuals with Intellectual and Developmental Disabilities (IDD) often experience difficulties in using these life-improving technologies due to challenges in access to AT and supports. Adequate and equitable assess to technology in coordination with services and supports to use technology and access virtual supports is critical.

This workgroup is tasked with recommendations to increase access to telehealth supports and services for individuals with IDD by promoting access to assistive technology (AT) and environmental modifications (EM).

Current Landscape

As defined in both the CCC Plus Waiver[1] and the DD Waiver Provider Manuals[2], Assistive Technology and Environmental Modifications are medically necessary services and includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance.

Assistive Technology (AT)

AT services are "specialized medical equipment and supplies, including those devices, controls, or appliances, that are medically necessary to enable individuals to increase their ability to perform acts of daily living (ADLs) or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. AT devices are expected to be portable." Each AT item must be recommended and determined appropriate to meet the individual's needs prior to approval by the Service Authorization contractor.

Allowable services under AT, not available under the Virginia State Plan, include specialized medical equipment, ancillary equipment, supplies necessary for life support and adaptive devices, appliances that enable an individual to be more independent, durable or non-durable medical equipment (DME), and equipment and devices that enable an individual to communicate more effectively. The maximum Medicaid-funded expenditure for AT is $5,000.00 per year. Unused portions of the maximum amount are not to be carried over from one year to the next.

Environmental Modifications (EM)

These physical adaptations must be necessary to ensure the health, welfare and safety of the individual. These services are not considered a "stand alone" service and can only be authorized in conjunction with at least one other authorized waiver service. "Medically necessary" includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit. Allowable services include but are not limited to physical adaptations to the individual's primary residence or modifications to the primary vehicle being used by the waiver individual.

EM must be available for a maximum Medicaid-funded amount of $5,000 per household per year. Costs for EM cannot be carried over from one year to the next.

Individuals with intellectual and developmental disabilities (I/DD)

The funding streams associated with AT/EM are as follows.

- **CCC Plus Waiver** for members with IDD that may or may not be on the DD Waiver waitlist. AT/EM are both covered by the member's MCO. Members include older adults, individuals who have a disability and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. They have chosen to receive Medicaid long-term services and supports through the HCBS waiver versus services in an institutional setting.
- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit** is geared to the early assessment of children's health care needs through periodic screenings and members may receive AT/EM based on whether a service is medically necessary. This takes into account a particular child's needs.
- **DD Waiver** for members who are receiving services through the Community Living (CL), the Family and Individual Support (FIS), or the

[1] Commonwealth Coordinated Care Plus Waiver Services Provider Manual, Chapter IV, 5/1/2019

[2] Developmental Disabilities Waiver Services Provider Manual, Chapter IV, 11/21/2013

Building Independence (BI) waivers, known as the DD waivers, are enrolled in the CCC Plus managed care program for their non-waiver services only. DD waiver services are covered through Medicaid fee-for-service. Under any of these waivers, AT/EM is reimbursed as a 'carved out' service for members/individuals enrolled in managed care. The IDD waiver member population is reflected in the chart below:

Priority Level	DD Wait List	DD Waiver	DD Waiver Slot Assignment	CCC Plus Waiver*
Priority 1	3,440	BI	353	n/a
Priority 2	6,678	CL	11,702	n/a
Priority 3	3,938	FIS	3,590	n/a
Total:	**14,056**	**-**	**15,645**	**4,534**

(Population data of 8/27/2021)
*These are members on the DD Waiver waitlist who are already receiving waiver services under the CCC Plus Waiver.

Virtual Supports

This workgroup defines "virtual supports" as not being a service, but rather a delivery model for accessing approved services from providers and in the setting of the person's choice to meet their individual needs. However, as a Medicaid reimbursed service or support, virtual supports is synonymous with telehealth and must meet the pertinent requirements related to HIPPA.

In an effort to minimize the spread of the COVID-19 virus, CMS authorized DMAS, through its Appendix K amendment, to implement certain waiver flexibilities. One such flexibility involved the use of telehealth technology for the following targeted services:

- Therapeutic Consultation Services
- Group Day Support
- Community Engagement /Community Coaching
- In-Home Residential Support Services
- Services Facilitation

Originally intended to be a temporary response to the pandemic, Virginia is now exploring permanent options for telehealth service delivery to enhance independence for individuals with IDD. A cornerstone to virtual HCBS service delivery is to incorporate critical technology options to modernize service delivery models. Budget Bill 1800 (Chapter 552) Item #313 (Appendix II) directed DMAS, in coordination with Department of Behavioral Health and Developmental Services (DBHDS), to amend options in its 1915(c) HCBS waivers to create permanent telehealth and virtual and/or distance learning as a permanent service option and accommodation for individuals within the complement of DD Waiver allowable services. A workgroup was convened in May 2021, which offered recommendations in policies and substance to amend the existing 1915(c) HCBS waiver services to allow telehealth as a permanent service option for individuals on one of the DD waivers. Telehealth is not intended to supplant integrated community-based services, but rather offer options and choice based on modernization of services options and equity.

However, policy and administrative concerns disrupt access to specialized technology, thereby limiting options for telehealth services for members with IDD. This legislative action directs DMAS to assemble a workgroup to study options that support the expansion of access to this technology.

Workgroup

DMAS gave careful consideration to several relevant stakeholders when forming the workgroup. Along with members from The Arc of Virginia, who collaborated on this particular legislation, the workgroup was comprised of parents, parent advocates, self-advocates, the Virginia Association of Health Plans, as well as subject matter experts from DMAS and DBHDS. In addition, there was a cross section of providers, provider associations, and advocacy groups; these included the Virginia Association of Centers for Independent Living (VACIL), Virginia Board for People with Disabilities (VBPD), vaACCSES, Virginia Network of Private Providers, Virginia Association of Community Services Boards, SafeinHome, and Rest Assured. (Appendix III)

Four (4) virtual working sessions occurred in August and September 2021. The group identified a vision for the work set before them that established the long term objective and guided the group towards a robust set of recommendations.

VISION: There is provider capacity and statewide infrastructure to support the availability and use of assistive technology and environmental modifications by people with intellectual and developmental disabilities to further promote access to telehealth, community living, and employment.

At the outset of the workgroup, the group described multiple barriers in current programs and processes to increasing access to technology. The stakeholders developed the following problem statement:

Problem Statement: In order to eliminate disparities in access to telehealth and the technology that enables it, Virginia will address critical infrastructure barriers to support the assistive technology and environmental modification needs of individuals receiving Medicaid 1915(c) waiver services. Specific barriers include: 1) provider capacity; 2) the lack of a functional process for required assessment, pre-approval, and obtaining the service, including installation, training, and modifications; and 3) inconsistent interpretation of regulations across the system.

Findings

Barriers to Increased Access

Provider Capacity is strained and AT and EM provider shortages are rising due to budget restrictions and administrative burdens. The Managed Care Organizations' (MCO) DME networks are reportedly closed to enrolling new providers, subsequently eliminating credentialing opportunities for AT and EM providers who are classified as a DME provider. Providers report that it is too difficult for vendors to stay in business. The cost of material, equipment, and supplies has risen and the existing budget limit is too low to provide adequate access to modernized specialized technology necessary to increase abilities and sustain access in hard to reach locations of the state. Additionally, the limits are inadequate for technology facilitation and implementation to cover applicable coordination costs incurred by providers.

Lack of Functional Processes has caused difficulties for members, caregivers, and providers to navigate through the complexities of Managed Care and Medicaid Fee for Service systems through which services are approved and reimbursed. Members without a case worker/case manager/support coordinator are missing direct access to a skilled point of contact who can help navigate and access AT and EM. Further, many case managers and advocates lack awareness of available technologies. Lack of training adds to dated systems which do not adequately leverage technology to support people with IDD through telehealth. Further, limits to the availability of required assessments and varied authorization processes across waivers and MCOs have reportedly caused disparities in equitable access to AT and EM.

Inconsistent interpretation of regulations across the system has reportedly resulted in disparities in equitable access to AT and EM. Variances exist between the CCC Plus Waiver regulations and DD Waiver Regulations. Service Authorization parameters are difficult to understand and regulatory interpretations of whether a request is a "health/safety" need as opposed to a caregiver convenience need have reportedly resulted in inconsistent denials and burdensome appeals. Current policy interpretation does not account for the changing definition of access to the community and necessary resources for proper functioning of AT.

Assistive Technology for anyone 21 years and younger on the CCC Plus Waiver is to be received through EPSDT. There are reported variations to policy interpretation and approvals vary across managed care and fee for service. MCOs reportedly only apply the EPSDT criteria for approval and inconsistently interpret the EPSDT medical necessity criteria that the requested services must "correct or ameliorate defects and physical and mental illnesses and conditions."

Recommendations

The workgroup developed a robust list of barriers to solve in order promote access to AT/EM. As such, the workgroup has agreed to continue discussions if directed on the recommendations that follow. The group has identified several near term, potentially actionable recommendations that address the three (3) key barriers discussed above. DMAS must research and conduct analysis of current data, processes, rules, and requirements, and work with management and our federal partners to identify what legislative, budgetary, and federal authority we can pursue in order to act on these Phase I recommendations.

Additional recommendations with more extensive budgetary, contractual, and federal implications are also included. Once the initial recommendations are addressed, the group can pivot to refining the critical work streams associated with each of the Phase II recommendations.

Provider Capacity

Phase I:

- Combine Budget Caps. DMAS would research options on the $5,000 annual cap on Assistive Technology, the $5,000 annual cap on Environmental Modifications, and the $5,000 annual cap on Electronic Home-Based Supports to be a combined $15,000 cap across all of these services for each individual based on their benefit eligibility. This could enhance the capacity for an individual to purchase necessary but expensive items and services. However, this would potentially require a waiver amendment

as well as changes in the Medicaid Enterprise, MCO and Waiver Management Systems.
- Research MCO Credentialing of DME Providers. DMAS would collaborate with MCOs and explore how to enhance the AT and EM provider network.
- Enhance Provider Training. Provider workforce modernization is needed, including education and training about using technology to deliver, receive, and audit virtual supports.

Phase II:

- Review the addition of Administrative Overhead to the current rate methodologies.
- Research increasing the service budget limitations.

Lack of Functional Processes

Phase I:

- Designate a DMAS AT/EM Subject Matter Expert (SME). A SME who is responsible for training, answering questions, developing policy, and program monitoring is recommended. The SME may also serve as a member/provider navigator for individuals not enrolled in managed care or a DD Waiver and develop resources such as workflows for individuals to successfully use their Assistive Technology, Environmental Modifications, and Electronic Home-Based Supports benefits, including referral, assessment/recommendation, approval, setup and training, and applicable payment.
- Review what types of items fall under each of these HCBS waiver programs. DMAS is currently promulgating regulations for the CCC Plus Waiver but may need additional authority to continue modifying regulations. Changes might also necessitate waiver amendments.
- Develop approval process for a “suite” of covered products instead of the current process of approvals needed for each related item or service. DMAS could explore the development of single approval process for a “suite” or collection of covered products using single approval process. This would include basic upkeep of equipment/technology, etc.

Phase II:

- Standardize MCO Service Review and Appeals Processes.
- Ensure consistent application of requirements for approvals for technology across Waivers and FFS.
- Research Assistive Technology, Environmental Modifications, and Electronic Home-Based Supports as a Consumer Directed Service option as well as the fiscal impact of the addition of services.

Inconsistent Interpretation of Regulations Across the System

Phase I:

- MCO and Provider Education around the Waiver and EPSDT Criteria. DMAS may develop guidance and education associated with the requirement that measures are required "to correct or ameliorate defects and physical and mental illnesses and conditions.”
- Continued monitoring of MCO and KePro determinations of EPSDT AT. DMAS may review the application of EPSDT criteria for purposes of monitoring and to also inform training needs.

Phase II:

- Explore policy implications related to situations where an item is denied through EPSDT, that it may still be considered under the AT and EM criteria for the CCC+ waiver.
- Clarify manual rules surrounding “AT is not covered for purposes of convenience for the caregiver” to delineate that safety of the member is not a convenience to the caregiver.

Conclusion

COVID-19 had a significant impact on Medicaid members who received home and community-based services. In order to manage their risk of COVID exposure, access to their regular caregivers or home and community-based treatment providers was significantly limited. Those flexibilities have identified areas of opportunity to expand and improve the delivery and receipt of Medicaid services. Virginia will continue to explore permanent options to telehealth service delivery and accommodations within HCBS waiver services. Future stakeholder workgroups would be engaged to continue to examine how to ensure adequate and equitable access to assistive technology (AT) and environmental modifications (EM) that promote telehealth options for individuals with intellectual and developmental disabilities.

Appendix

I. Appendix K

Appendix K is a standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency.

II. Budget Bill 1800 (Chapter 552) Item #313

"DDDDDD. The Department of Medical Assistance Services, in coordination with the Department of Behavioral Health and Developmental Services, shall submit a request to the Centers for Medicare and Medicaid Services to amend its 1915(c) Home & Community-Based Services (HCBS) waivers to allow telehealth and virtual and/or distance learning as a permanent service option and accommodation for individuals on the Community Living, Family and Individual Services and Building Independence Waivers. The amendment, at a minimum, shall include all services currently authorized for telehealth and virtual options during the COVID-19 pandemic. The departments shall actively work with the established Developmental Disability Waiver Advisory Committee and other appropriate stakeholders in the development of the amendment including service elements and rate methodologies. The department shall have the authority to implement these changes prior to the completion of the regulatory process."

III. Workgroup Members

Workgroup Member	Organization
Andrew Greer **Nichole Martin** **Kimberly Ryan Ruffo** **Ann Bevan** **Donna Boyce** **Jason Perkins** **Elizabeth Smith** **Jason Rachel** **Brian Campbell** **Angie Vardell**	DMAS
Doug Gray, VAHP	Virginia Association of Health Plans
Maureen Hollowell	Virginia Association of Centers for Independent Living
Tonya Milling	The Arc of Virginia
Jesse Monroe	Member Advocate
Shannon Richard **Debra Holloway** **Kimberly Osam**	Parent Advocate
Ann Flippin	Autism Society of Central Virginia
Teri Morgan	Virginia Board for People with Disabilities
Heather Norton **Dawn Traver**	Department of Behavioral Health and Developmental Services
Andrea Vincent- (Safe in Home) **Ryan Green- (BrightSring Health)** **Tracy Brumbaugh - (Rest Assured)** **John Weatherspoon – (Wall Residences)** **Sarah Craddock – (DPSC)** **Maria McWirt (MPower Me)**	Providers
Karen Tefelski	VaAccses
Jennifer Fidura	Virginia Network Of Private Providers
Jennifer Faison	Virginia Association of Community Services Boards