REPORT OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Permanent Use of Virtual Supports Focused on Assistive Technology (AT)/Environmental Modifications (EM) Services (Chapter 222, 2022)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 7

COMMONWEALTH OF VIRGINIA
RICHMOND
2022

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 31, 2022

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor of Virginia

C. Todd Gilbert
Speaker, Virginia House of Delegates

Richard L. Saslaw
Majority Leader, Senate of Virginia

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Workgroup and Recommendations for Virtual Supports Focused on AT/EM Services

This report is submitted pursuant to the Virginia Acts of the Assembly – Chapter 221 (HB990), which states:

The Department of Medical Assistance Services shall continue the 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, 2022.

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

CJR

Enclosure

Pc: The Honorable John Littel, Secretary of Health and Human Resources

Permanent Use of Virtual Supports Focused on AT/EM Services

A Report to the Virginia General Assembly

October 31, 2022

Report Mandate:

Chapter 221, Section 1 (HB990) of the 2022 General Assembly Session States: **"***The Department of Medical Assistance Services shall continue the 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, 2022."*

Background

COVID-19 significantly impacted Medicaid members, including members receiving home and community-based services (HCBS). In order to reduce their risk of COVID-19 exposure, certain flexibilities were identified and authorized by the Centers for Medicare and Medicaid Services (CMS), through an Appendix K amendment to the waiver application. This appendix was developed as a standalone appendix to be utilized by the state during emergency situations. It includes actions that states can take under the existing Section 1915(c) HCBS waiver authority in order to respond to an emergency.

Virtual support is a delivery model for accessing approved Medicaid services. It is synonymous with telehealth and must meet the pertinent requirements related to the Health Insurance Portability and Accountability Act (HIPAA). Since the term "Virtual Supports" is not recognized or defined, the term "Telehealth" (DMAS, n.d.) is used instead. Telehealth offers options and choice based on modernization of service delivery options and equity and is not intended to supplant integrated, community-based services.

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 intellectual and developmental disabilities (IDD). In 2021, as directed by HB2197, the Department of Medical Assistance Services (DMAS) convened a workgroup and reported options and recommendations on increasing access to telehealth and services for individuals with intellectual and developmental disabilities by promoting access to assistive technology (AT) and environmental modifications (EM). This year, HB990 directed DMAS to continue the workgroup and develop recommendations for the permanent use of telehealth and increased access to virtual supports and services by promoting access to assistive technology and environmental modifications for individuals with IDD.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 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 600,000 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 an approximate 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% for newly eligible adults, generating cost savings that benefit the overall state budget.

Workgroup

The workgroup convened on July 7, 2022, as directed by HB990 (and its companion SB232). DMAS facilitated five workgroup sessions between July 7, 2022, and August 25, 2022. The group included parents, parent advocates, self-advocates, representatives from The Arc of Virginia, Virginia Association of Health Plans, subject matter experts from DMAS and the Department of Behavioral Health and Developmental Services (DBHDS), a cross section of providers, provider associations, and advocacy groups; namely Virginia Association of Centers for Independent Living (VACIL), Virginia Board for People with Disabilities (VBPD), Virginia Association of Community Rehabilitation Programs (vaACCSES), Virginia Network of Private Providers, Virginia Association of Community Services Boards, Safe in Home, and Wall Residences. *(Appendix III)*

Workgroup members re-engaged DMAS in discussions and further research pertaining to some of last year's recommendations, including the proposed legislation to combine budget caps, in addition to research of other states that have implemented some of the recommended programmatic approaches, such as the consumer-directed service option. The group also reviewed and discussed current program rules and made some proposed policy and provider training recommendations.

Workgroup Actions

The workgroup highlighted the strain on provider capacity due to budget restrictions and administrative burdens. Providers report that it is too difficult for vendors to stay in business. The existing budget limit for specialized technology is not adequate for the rising costs of material, equipment, and supplies, leaving the costs for technology facilitation, coordination, and implementation uncovered and absorbed by the provider. Provider capacity issues also cause delay in members getting what they need. Workgroup members discussed that another barrier to members accessing services is the lack of providers who can conduct the initial assessment to obtain AT/EM. The workgroup was interested in consumer-directed service options that would increase member choice and address some of the provider capacity issues. They suggested that this would cut out the need for a third party and would provide members direct access to the needed technology. The workgroup suggested reviewing other state's programs to see if consumer-directed service options were viable and could be explored in Virginia. They suggested that this may be a lower cost option for purchasing AT.

At the request of the workgroup, DMAS queried Fiscal Management Service (FMS) vendors who perform consumer-directed payroll activities in Virginia to learn about AT/EM options they support in other states. The consumer-directed models explored included those in Massachusetts, Minnesota, West Virginia and Idaho. The focus of the research was to learn the program mechanics of the consumer-directed models and how the items are procured. DMAS examined the three options listed below.

1.) Direct reimbursement to the Medicaid Member for purchased items: After the member enrolls with the FMS vendor they submit a request or application for reimbursement. The FMS reviews the request and sends a check to the member for the item. Members of the workgroup urged caution in this model as it would require the member or the family to initially utilize their own funding to purchase the item. This could put a strain on the member/family and could potentially make this option out of reach to some members.

2.) FMS initiate purchases: A request is made for items with a specified vendor. The FMS orders the item and submits payment to the vendor. The states that use this approach have also instituted individualized budgets. Individualized budgets are allocated to the Medicaid Member based on the identified needs; the Member is in control of the budget and supports purchased. While not specifically explored, the cost of the FMS vendor to perform this service must be taken into account. Some workgroup members felt this method was not the consumer-directed option they desired and may still result in long wait times to receive the service(s) due to supply shortages.

3.) Pre-payment to member: Providing upfront funding to the member to purchase items. The member would request the item and indicate the funding amount needed. The FMS vendor reviews the request and sends a check to the member to be able to purchase the item. This option would require post-payment review to ensure items are purchased with the funding provided. The cost of the FMS vendor to perform this service must also be taken into

account. The FMS vendors indicated that this option has program integrity ramifications and requires intense scrutiny.

The VABPD requested information from other state DD councils about successful consumer-directed models for AT and EM. Feedback was obtained from Maryland, Wisconsin, and Ohio. VBPD and DMAS spoke to a provider of AT in Maryland who explained their process for procuring items that cost under $1,000, which includes not requiring an assessment for AT that is under the $1,000 threshold. Enrolled providers purchase the item based on the member's individualized service plan. The provider can be reimbursed for up to nine hours for administrative time for work involved with procuring the item. While this model is not consumer-directed or cost-neutral, it does provide some insight on an alternative that could address the provider shortage for these services.

Recommendations:

Adding Administrative Overhead and Implementation Funds

Although not technically consumer-directed nor cost neutral, the example from Maryland where providers can be reimbursed for administrative work involved with procuring items under a certain cost threshold could be a viable option. This is similar to what is allowed in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Durable Medical Equipment (DME) for unique items that do not have an established reimbursement rate. DMAS would need appropriation authority to proceed. The ability for the provider to bill for nine hours of work may not be feasible or necessary, but more research is needed.

Combining Annual Budget Caps

Advocates from the workgroup indicated their intention of re-submitting legislation to combine the annual budget caps for assistive technology, electronic home-based support services, and environmental modifications as proposed during the 2022 legislative session. This would require appropriation authority. Advocates would be interested in working with DMAS in determining the fiscal impact.

Policy Update Recommendations and Education and Training Needs

The workgroup recommended provider education and training be conducted. Collaboration and education with DMAS' managed care and fee-for-service (FFS) service authorization entities is recommended to ensure consistent application of requirements for approvals for technology across programs and delivery systems. The workgroup reiterated the need to clarify the AT service limitation that prohibits services for purposes of convenience of the caregiver or paid staff. As policy updates are enacted, the workgroup recommends that the policy is broad enough to address evolving technologies and frequent innovations in technology. Advocates from the workgroup developed an EM, AT, Electronic Home-Based Support (EHBS) Service provider guidance document and flow chart. DMAS is looking at ways to incorporate this material into existing guidance documents already in effect. CCC Plus Waiver training is currently under development, which will incorporate education of EM, AT, and EHBS access processes within this waiver program. This is in line with the workgroup's suggestion that clarifications be included on the application of CCC Plus Waiver AT services when denied under EPSDT. Additionally, the workgroup members recommended Virginia and its partners review best practices from states identified as "Technology First" states, such as Ohio.

DMAS would like to acknowledge the members of the Workgroup and thank them for contributing their time, expertise, and recommended approaches to promote access to assistive technology and environmental modifications in order to help increase access to telehealth for individuals with intellectual and developmental disabilities.

Appendix

I. 2021 Special Session I, 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."

II. Phase One Services

Phase One Services involve those services that needed no regulatory change, no waiver amendment change, no rate change, no rate code change, and/or no system change.

Phase One Services:

- **Benefits Planning Services [12VAC30-122-280]:** All allowable activities could potentially be conducted by telehealth. DMAS and DBHDS will examine the parameters and articulate guidance in the policy manual and eventually the regulations when given authority.
- **Community Engagement [12VAC30-122-320]:** Some of the assessment information could be gathered via telehealth; however, some level of the assessment must be completed in person to ensure that observation is demonstrated. Services to be completed via telehealth must be well articulated in the plan for supports and limited to a % of the authorized and delivered hours in any given day/week. Additional parameters and guidance will be articulated in the policy manual and eventually the regulations when given authority.
- **Community Guide [12VAC30-122-330]:** There are a number of non-face-to-face activities that may be conducted up to a % of the total units authorized and delivered in any given week. DMAS and DBHDS will examine the parameters and articulate guidance in the policy manual and eventually the regulation when given authority.
- **Individual and Family/Caregiver Training [12VAC30-122-430]:** All elements could be accomplished via telehealth where not clinically prohibited. DMAS and DBHDS will examine the parameters and articulate guidance in the policy manual and eventually the regulation when given authority.
- **Independent Living Support Services [12VAC30-122-420]:** In general, all allowable activities listed in 12VAC30-420.B could be provided via telehealth, but limited to no more than a % of the authorized and delivered hours in a given week. DMAS and DBHDS will examine the parameters and articulate guidance in the policy manual and eventually the regulation when given authority.
- **In-home Support Services [12VAC30-122-410]:** In general, allowable activities listed in B.2 related to assessment and some skill-building could be virtual but limited to no more than a percentage of the authorized and delivered hours in a given day/week. Additional parameters and guidance will be articulated in the policy manual and eventually the regulations when given authority.
- **Peer Mentor Services [12VAC30-122-450]:** In general, all allowable activities could be delivered via telehealth with the individual's permission. DMAS and DBHDS will examine the parameters and articulate guidance in the policy manual and eventually the regulation when given authority.
- **Services Facilitation [12VAC30-122-500.E.3.e]:** Management training. Some calls related to the training and collateral contacts can be done via telehealth; however, comprehensive, routine, and reassessment visits must be

conducted in person. DMAS and DBHDS will examine the parameters and articulate guidance in the policy manual and eventually the regulation when given authority.

- **Therapeutic Consultation [12VAC30-122-550]:** Certain aspects of assessments and interviewing and consultation as determined clinically appropriate by the consultant may be accomplished via telehealth. There is already reference to this in regulations, but DMAS will ensure the waiver applications are amended.

III. Workgroup Members

Organization	Workgroup Member
DMAS	Andrew Greer Nichole Martin Nina Burrell-Braxton Ann Bevan Donna Boyce Jason Perkins Jason Rachel Brian Campbell Angie Vardell
Virginia Association of Health Plans	Heidi Dix Doug Gray
Virginia Association of Centers for Independent Living	Maureen Hollowell
The Arc of Virginia	Tonya Milling
Member Advocate	Jesse Monroe
Parent Advocate	Debra Holloway Kimberly Osam
Virginia Board for People with Disabilities	Teri Morgan
Department of Behavioral Health and Developmental Services	Heather Norton
Providers	Andrea Vincent- (Safe in Home) John Weatherspoon – (Wall Residences) Sarah Craddock – (DPSC)
vaACCSES	Karen Tefelski
Virginia Network Of Private Providers	Jennifer Fidura
Virginia Association of Community Services Boards	Jennifer Faison