



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services

Bill J. Crouch
Cabinet Secretary

Cynthia E. Beane
Commissioner

March 23, 2020

Dan Belnap, State Lead
United States Department of Health and Human Services
Centers for Medicare and Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106

RE: West Virginia 1135 Waiver Request

Dear Mr. Belnap:

The West Virginia (State) Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS or Bureau) **hereby submits a waiver request**, pursuant to Section 1135 of the Social Security Act from the Centers for Medicare and Medicaid Services (CMS), to modify certain Medicaid program requirements, policies, operational procedures, and deadlines applicable to the State's administration of its Medicaid program and West Virginia Children's Health Insurance Program (WVCHIP) during the period of the national state of emergency to prevent further transmission of the Coronavirus Disease (COVID-19).

The goal of this waiver request is to ensure that Medicaid and WVCHIP members continue to receive medically necessary covered services while minimizing the exposure of COVID-19 to members, providers, and medical staff. In addition, DHHR requests confirmation that any approved flexibility granted with respect to fee-for-service Medicaid benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medicaid managed care plans, public health systems, specialized mental health plans, and pharmacy systems, and to the State's standalone Children's Health Insurance Program.

Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHHR may subsequently request approval for additional flexibilities, which we will do as soon as the need is discovered. Such modifications, to the extent possible, would be effective coinciding with the President's declaration of a national state of emergency on March 13, 2020, with a **retroactive effective date of January 31, 2020**. The modifications for the requested Section 1135 flexibilities would coincide with the effective start date of the national state of emergency unless otherwise specified.

Due to the need for social distancing, BMS anticipates operating its Medicaid program with the majority of its employees and vendors working remotely to administer the State's Medicaid program. Additionally, nursing facilities and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) will have restricted visitors, which will temporarily halt the delivery of family assistance services to elderly and fragile individuals.

Per 42 CFR §483.35(a), BMS also requests waiving the requirements for minimum nursing employees, including:

- Waive the requirement that the facility have sufficient nursing personnel on a 24-hour basis;
- Waive the requirement that the facility designate a charge nurse for each tour of duty; and
- Waive the requirement that a registered nurse must be in a facility for eight (8) consecutive hours, seven (7) days per week.

Per 42 CFR §483.35(c)-(d) and 42 CFR §483.95(g), BMS also requests the waiver of all requirements relating to nurse aide competency, training, re-training, and evaluation, to permit flexibility to secure staffing in crisis period, including:

- Permitting non-clinical staff to provide certain types of clinical care;
- Allowing potential nurse aides to undergo one-on-one, on-the-job training, instead of completing the formal nurse aide training and evaluation; and
- Saving administrative time by removing the requirement that a nurse aide receive a performance evaluation every twelve (12) months for the remainder of 2020.

Regarding nurse staffing information, per 42 CFR §483.35(g), BMS requests waiving the requirement that employee numbers be posted at the start of each shift and waiving the requirement to retain this data during the same timeframe.

Eligibility Flexibilities

The priority of DHHR is to ensure new Medicaid and WVCHIP applications and renewals can be processed in a timely manner. Therefore, pursuant to 42 CFR §435.912(e)(2), the State requests the **postponement of processing annual eligibility renewals** for Medicaid and WVCHIP members scheduled to occur in March-May 2020, or until the termination of the March 13, 2020, COVID-19 declaration of emergency, whichever is longer. This request includes suspension of adverse actions to respond to changes in any eligibility factors, which include, but are not limited to, factors such as income, category, and age. This request also **includes accepting the member's statement for verification of eligibility criteria for which documentation cannot be readily acquired.**

BMS requests the **expansion of presumptive eligibility (PE) to include the over-65, aged and disabled population.** With the onset of COVID-19 in West Virginia, the need to expand this benefit to some of the more vulnerable populations has become necessary. Through the 1135 waiver authority, BMS seeks to expand its PE populations to include

individuals who are age sixty-five (65) and older, blind, and/or disabled by ensuring that the most vulnerable individuals have access to care.

BMS also requests the waiver of costs associated with the testing of the COVID-19 and, for those that test positive, all costs associated with the treatment of this virus for certain beneficiaries subject to a share of cost. The waiver of cost-sharing for the COVID-19 testing, diagnosis, and treatment for this population will help ensure there are no financial barriers to seeking medical services related to this public health emergency and will help reduce the spread of the virus.

With the goal to promote the testing and treatment of the State's uninsured population, this request includes the expanded coverage of a temporary eligibility span to cover COVID-19 testing and treatment for individuals without insurance. In addition, the State requests the extension of eligibility re-determinations by at least three (3) months or the duration of the emergency, whichever is longer, for Medicaid and WVCHIP members.

State Fair Hearing Requests and Appeal Deadlines for Managed Care Enrollees

In order to provide flexibility to employees and members, BMS requests the temporary delay of select aspects of the Medicaid Fair Hearing process, including the scheduling of fair hearings and issuing fair hearing decisions during this emergency period. BMS requests the modifications of the timeframes under 42 CFR §438.408(f)(2) and 42 CFR §438.408 (b)(1) for members to exercise their appeal rights and for resolution to allow an additional 120 days to request a fair hearing and for resolution when the initial 120-day deadline for an enrollee occurred during the authorized period of the immediate Section 1135 waiver.

For standard resolution of a grievance and notice to the affected parties per 42 CFR §438.408 (b)(1), it is requested the timeframe is established by the State may not exceed 120 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

Benefit Flexibilities

In order to promote social distancing and to reduce the exposure for Medicaid and WVCHIP members and pharmacy providers to the virus, this waiver request includes allowing early refills and the supply (up to ninety {90} days) of certain non-controlled maintenance medications that will be dispensed with each fill. This request also includes a temporary case-by-case determination to allow prescriptions from non-enrolled prescribers to meet the demands of and lessen the burden on prescribers during this crisis.

DHHR requests recognition of any COVID-19 testing and related treatment of a member outside of an emergency room setting as constituting "emergency services" or services for an "emergency medical condition" for purposes of various Medicaid requirements including, but not limited to, 42 U.S.C. §1396u-2(b)(2) and 42 U.S.C. §1396b(v)(2)-(3).

All Medicaid medical co-pays and premiums for members and uninsured will be waived during this time as well. WVCHIP will waive both co-pays and WVCHIP Blue and Gold Premiums, as well as the WVCHIP Premium Plan for up to 6 months or until the end of the emergency, whichever is longer.

DHHR also requests federal financial participation for expenditures related to temporary housing for people experiencing homelessness as a result of the emergency, including but not limited to, commandeered hotels, other places of temporary residence, and other facilities that are suitable for use as places of temporary residence or medical facilities as necessary for quarantining, isolating, or treating individuals who test positive for COVID-19 or who have had a high-risk exposure and are thought to be in the incubation period of the virus.

DHHR requests a waiver of the institutions of mental disease (IMD) exclusion rule that prohibits reimbursing fee-for-service (FFS) behavioral healthcare and substance use disorder services performed for patients in IMDs (§1905(a)(30)(B), or large residential psychiatric institutions and treatment centers. To continue to serve the State's Medicaid behavioral health members during the COVID-19 pandemic, this waiver will enable reimbursement for FFS providers that provide treatment for adults under age sixty-five (65) in psychiatric residential facilities with more than sixteen (16) beds.

BMS is actively engaged in work to mitigate the impact of the opioid epidemic across the State. BMS has found that some recovery centers are shutting down in order to minimize close contact between members, but has concerns that the inability to obtain treatment may cause a rise in relapse and death as a result, not to mention the potential for increased interactions due to SUD.

BMS is proposing short-term and long-term recovery housing for members of these recovery centers that are in the process of shutting down by working with community leaders to rehabilitate unoccupied buildings. In the event the COVID-19 crisis continues long-term, the State can work to identify buildings for rehabilitation and members can utilize recovery services, both short-term and long-term, especially members that are experiencing chronic homelessness. These recovery buildings can partner with hotels and a number of social service resources such as local food banks, which can provide nutritious food options to the centers. By working to transform unoccupied buildings throughout the State to use as a safe recovery housing alternative for substance use disorder (SUD) members, the number of members entering hospitals and other institutions will be reduced.

Service Authorization and Utilization Controls

DHHR wants to ensure that Medicaid and WVCHIP members' access to care is not interrupted due to the remote, overwhelmed, and/or reduced healthcare workforce. BMS requests the waiver of prior authorization requirements, as may be necessary to facilitate a timely and efficient administration of benefits. We request non-emergent or elective procedures to be postponed where possible (unless emergent or deemed critical by diagnosis) by the care delivery community. We request prior authorization

requirements be expanded to allow for a member with COVID-19 symptoms to have the ability to access care without prior authorization, whether they are in or out of network.

In addition to these requests, the State requests:

- The waiver of prior authorization requirements for accessing covered State plan and/or waiver benefits (e.g., outpatient drugs pursuant to 42 U.S.C. §1396r–8(d)(5)) in recognition of various circumstances that make submission of medical necessity documentation difficult, impractical, or impossible. Such circumstances include, but are not limited to: relocation or isolation of Medicaid and WVCHIP beneficiaries; inaccessibility of resources provided by the facilities; and relocation, reassignment, or isolation (due to illness) of pharmacy staff, primary care prescribers and staff, and/or specialty prescribers and staff in the affected areas. During the authorized emergency period, DHHR intends for providers to submit uniquely identified manual claims for services that typically require prior authorization to the fiscal intermediary (FI). The FI will process the claims without regard to prior authorization requirements or documentation for the medical necessity of the service.
- Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) are lost, destroyed, irreparably damaged, or otherwise rendered unusable, the States requests contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers will still need to include a narrative description on the claim explaining the reason why the equipment must be replaced and will be reminded to maintain documentation indicating that the DMEPOS were lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.
- The waiver of State plan and waiver-imposed utilization controls on covered benefits to the extent such limits cannot be exceeded based on medical necessity in the relevant approved State plan or waiver authority.
- The waiver of limitations on who can prescribe certain covered benefits, such as to allow licensed practitioners to prescribe instead of only a physician, podiatrist, or dentist; home health services (42 CFR §440.70, to allow licensed practitioners to prescribe services such as DME, medical supplies, enteral nutrition, and home health agency services instead of only a physician); physical, occupational and speech therapies (42 CFR §440.110, to allow licensed practitioners to prescribe); and prosthetics (42 CFR §440.120, to allow licensed practitioners to prescribe within their scope of practice).
- The waiver of in-home face-to-face and/or in-home requirement for conducting reassessments and instead providing the option to conduct reassessments via telephone or other remote options for home health and other in-home state plan services. The State also requests a waiver to extend the reassessment period in all in-home based services to once every eighteen (18) months and to temporarily suspend quality assurance home visits.
- The waiver of Section 1927 of the Social Security Act and State Plan Supplement 2 #11 requiring documentation of published studies documenting the safety and effectiveness of unlabeled medication use, or recommendations for use by experts in the disease field in order to approve a Treatment Authorization Request (TAR) for

unlabeled use. BMS is requesting authority to cover and reimburse unlabeled medications shown to be safe and effective, but not yet having the required published documentation for use in COVID-19.

- The waiver to allow acute care hospitals with excluded, distinct part-inpatient psychiatric units that, as a result of a disaster or emergency, to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit.
- The waiver of the requirement at Section 1812(f) of the Social Security Act for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay.
- The waiver of requirements that critical access hospitals limit the number of beds to twenty-five (25) and that the length of stay be limited to ninety-six (96) hours.
- For individuals receiving services under the 1115 demonstration waiver “Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders” or the State Plan, the State requests:
 - The waiver of in-home face-to-face requirements for review of the service plan and conducting reassessments;
 - The waiver to utilize telephonic, live video, or other remote methods for the provision of services;
 - The waiver to provide services in alternate locations when necessary; and,
 - BMS also requests that facilities approved to operate a 3.1, 3.5, or 3.7 level program utilize flexible capacity between these three levels of care at the same site. At these sites, an approved Level 3.1, 3.5 or 3.7 program may utilize any available program space for a member to enter the program, but the member must still receive services according to the member’s assessed level of need.

Provider Participation, Billing Requirements, and Conditions for Payment

BMS also requests provisional or streamlined provider enrollment for non-enrolled State providers to ensure providers are paid for covered services during the pandemic. The Bureau also requests a waiver from certain provider staff qualification requirements to include initial and annual training including cardiopulmonary resuscitation (CPR); first aid; identifying and reporting abuse, neglect, and exploitation; confidentiality; crisis intervention and fingerprint based criminal background checks through WV Clearance for Access: Registry & Employment Screening (WV CARES) which will be suspended until the end of the emergency. Provider agencies may choose to provide online training for services such as CPR and first aid in lieu of in-person training and must complete online background checks prior to providing services. Trainings may also be conducted by telephone or web-based tools such as Skype or Zoom.

Seniors with multiple conditions are at the highest risk for infection and complications from COVID-19, including death. This 1135 request seeks a waiver of requirements that will directly and immediately impact West Virginia’s skilled nursing facility providers who service this most vulnerable population. These providers are facing an unprecedented situation of trying to protect and serve a vulnerable population in a time where resources and supply chains are stressed and maintaining adequate staffing is even more challenging. Nursing facilities already have difficulty in attracting and retaining

qualified staff, and school and daycare closures will put an even further strain on this already limited resource.

With regard to certified skilled nursing facilities operating in West Virginia, to help our state's skilled nursing facilities better protect their residents, keep the workforce safe and available, and free up additional to operate in these extraordinary times, BMS is requesting:

- The waiver of requirements related to **nurse aide competency**, training, re-training, and evaluation, to permit flexibility to secure staffing during the crisis period, including:
 - Permitting non-clinical employees to provide certain types of clinical care;
 - Allowing potential nurse aides to undergo one-on-one, on-the-job training, instead of completing the formal nurse aide training and evaluation; and,
 - Saving administrative time by removing the requirement that a nurse aide receives a performance evaluation every twelve (12) months for the remainder of 2020.
- The waiver of requirements for minimum **nursing staff**, including:
 - The requirement that the facility has sufficient nursing personnel on a 24-hour basis;
 - The requirement that the facility designates a charge nurse for each tour of duty; and,
 - That a registered nurse must be in a facility for eight (8) consecutive hours, seven (7) days per week.
- The waiver of **physician visit requirements**, per 42 CFR §483.30.
- The waiver of requirements that **staff numbers be posted** at the start of each shift and waive the requirement to retain this data during the same timeframe.
- With regard to documentation, the waiver of:
 - Per 42 CFR §483.106, requirements for **pre-admission screening and annual resident review** (PASRR) assessment requirements, including:
 - All Level 1 and Level 2 assessments for thirty (30) days;
 - Treating all **new admissions like exempted** hospital discharges;
 - When a resident is transferred between nursing facilities; and,
 - Providing Resident Reviews (RRs) only as resources are available.
 - Per 42 CFR §483.15(d)(2) and 42 CFR §483.15(c)(3)-(6), the **waiver of bed hold notice requirements** and transfer-and-discharge notice requirements.
 - Per 42 CFR §483.12(c)(1) and (4), **extending reporting requirements for abuse**, neglect, mistreatment, and misappropriation of resident property to within twenty-four (24) hours.
 - Per 42 CFR §483.10(e)(6)-(7), the waiver of the **resident's right** to receive written notice before the resident's room or roommate in the facility is changed and waiver of the resident's right to refuse to transfer rooms.
 - Per 42 CFR §483.90, the waiver of any requirement to conduct life safety equipment and systems **testing** that is completed by third parties (i.e., non-employees) of a SNF.
 - Per 42 CFR §455.434, the waiver of the requirement that the Medicaid program requires providers to consent to **criminal background checks** including fingerprinting.

This request includes waiving of certain provider enrollment requirements in order to maintain the capacity to meet member access needs during the emergency and to enable payment to affected providers for rendered services. During the approved emergency period, DHHR proposes to **streamline enrollment of providers** using relatively limited information, (i.e. provider information sufficient to build a case file for claims processing). DHHR would apply such flexibility to providers on a statewide basis and would require provider agreements but not disclosure statements. DHHR also proposes to waive requirements such as: **application fees** pursuant to 42 CFR §455.460; **criminal background checks** associated with Fingerprint-based Criminal Background Checks pursuant to 42 CFR §455.434; site visits pursuant to 42 CFR §455.432; screening levels pursuant to 42 CFR §424.518; **in-state/territory licensure requirements** pursuant to 42 CFR §455.412 and disclosures and disclosure statement pursuant to 42 CFR §455.104.

- For those providers located **out of the State** and from which State Medicaid participants seek care, BMS is requesting to **not be required to enroll these providers** if the following criteria are met:
 - The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location– i.e., located outside the geographical boundaries of the reimbursing state/territory’s Medicaid plan.
 - The National Provider Identifier (NPI) of the furnishing provider is represented on the claim.
 - The furnishing provider is enrolled and in an “approved” status in the Medicaid plan.
 - The claim represents services furnished, and;
 - The claim represents either:
 - A single instance of care furnished over a 180-day period, or
 - Multiple instances of care furnished to a single participant, over a 180-day period.
- Additionally, BMS seeks to **temporarily cease revalidation of providers** who are located in West Virginia or are otherwise directly impacted by the emergency.
- BMS also requests waiver authority **to enroll providers who are not currently enrolled** by meeting the following minimum requirements:
 - Must collect minimum data requirements in order to file claims and process, including, but not limited to NPI.
 - Must collect Social Security Number, Employer Identification Number, and Taxpayer Identification Number (SSN/EIN/TIN) in order to perform the following screening requirements:
 - OIG exclusion list; and,
 - State licensure – provider must be licensed, and legally authorized, in any state/territory to practice or deliver the services for which they intend to file claims.
 - BMS may grant a **provisional temporary enrollment** that meets the following requirements:

- Must cease approving temporary provisional enrollments no later than the date that the emergency designation is lifted.
- Must cease payment to providers who are temporarily enrolled within six (6) months from the date that the emergency designation is lifted, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved.
- BMS may allow a retroactive effective date for provisional temporary enrollments that coincides with the date of the emergency declaration.
- The waiver of managed care organization (MCO) requirements that require complete credentialing of providers required under 42 CFR § 438.214.

DHHR requests a waiver to modify the number and types of staff onsite at the State's behavioral health facilities, which will enable elect behavioral codes previous to be allowed through an audit because of the waiver of current onsite requirements. Select social workers (licensed clinical social workers or graduate social workers) that needed to be affiliated with enrolled providers in order to have supervisory abilities, would now be able to provide services as part of this waiver. In addition, DHHR also requests the waiver of the current requirement to have a minimum two staff members onsite to provide services.

With regard to alternative settings, DHHR requests a blanket waiver to allow enrolled providers and facilities to provide services in an unenrolled alternative setting, such as a temporary shelter when a provider's facility is inaccessible, or the need arises to repurpose certain areas.

Clinical Laboratory Improvement Amendments (CLIA)

The recent emergency declaration gives the U.S. Secretary of Health and Human Services (HHS) vast authority to waive certain laws and regulations to provide the U.S. healthcare system "maximum flexibility to respond to the virus". Unfortunately, clinical laboratories across the U.S. are hampered in their efforts to respond to COVID-19 by the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

The federal Clinical Laboratory Improvement Advisory Committee recently recommended allowing qualified professionals to review and interpret digital images remotely when data is exchanged via a secure connection. Many U.S. laboratories have well-validated digital systems or are developing systems that allow for quality remote diagnosis using secure virtual personal networks (VPNs) - this includes pathology laboratories in West Virginia. Given dire shortages of pathologists and laboratory personnel at many laboratories and the need to follow the President's call for social distancing, DHHR is requesting a waiver of certain requirements of the CLIA to allow pathologists and laboratory professionals flexibility in remote diagnosis consistent with the flexibility allowed by HHS for other physician specialties who provide telemedicine services.

Telehealth/Virtual Visits

DHHR requests flexibility to allow for **all services**, including all medical, DME equipment, and **behavioral health** services, to be rendered via telehealth during the emergency, and requests the following:

- That all **School-Based Health Services** continue to be rendered to ensure students with individualized education programs (IEP) and their families can continue to receive services during COVID-19 pandemic. These services would be delivered through telehealth services. Typically, a child may not receive School-Based Health Services if they are not in attendance at school and must have collateral services taking place. Because of COVID-19, we believe it is important that **the following services continue**, and waiver requests are addressed for the safety of these vulnerable students.
- Waive the requirement that in order to bill for a telehealth service a provider must have billed that Medicaid or Medicare enrollee for a service within the previous three (3) years.
- Allow E&M codes to be billed via telehealth or telephonic services even for first time patients.
- Allow for reimbursement for telephone visits **at the same rate** as telehealth video visits.
- Allow **capacity funding** for providers, which may include grants, other Medicaid financing, or other dollars granted to Medicaid agencies during the crisis.
- Provide **indemnify/hold harmless for emergency telehealth** services.
- Flexibility to allow for virtual/telephonic communication/telehealth modalities for covered State plan benefits, including but not limited to **behavioral health** treatment, where medically appropriate and feasible.
- The **waiver of a face-to-face encounter requirement** for reimbursement in 42 CFR §405.2463(a)(B)(3) and 42 CFR §440.90 (a) for **federally qualified health centers (FQHC) and rural health clinics (RHC)** relative to covered services via telehealth provided by clinic providers—additionally, allowing flexibility to provide these covered services via telehealth without regard to the date of the last visit and for new or established clinic patients.
- **BMS is allowing all State Plan and 1115 SUD waiver behavioral health services that it deemed clinically appropriate to be provided via telehealth and telephonically.**
- The waiver of any State Plan requirements for a "face-to-face contact between the member and a treatment staff person of the facility on the day of service" for **Adult Residential Treatment Services** and **Crisis Residential** and allow that requirement to be fulfilled by telephone or telehealth.

Payment Rates

BMS requests relief for all clinicians, providers, hospitals, and facilities through the application of alternative payment methodologies in response to COVID-19 in order to remove barriers that interfere with needed and necessary services.

BMS also requests the waiver of State Plan Attachment 4.19-D, which establishes the provision for reimbursement of Intermediate Care Facilities. Members using ICF

services often participate in day programs, which reduces the need for staffing in facilities while clients are in these programs. ICF rates account for this reduced staff time. ICF day programs are being suspended to prevent the spread of COVID-19 resulting in clients needing to stay within their facilities and increasing the cost for facilities to have adequate staff. The assumed participation time in the day programs are not built into ICF rates. The State seeks to waive the current ICF rate-setting methodology to provide an add-on to facility rates to compensate for the increased cost of staff time not accounted for in the current facility's daily rates during the duration of the emergency.

Administrative Activities

Regarding deadlines and timetables for the performance of required activities, BMS requests the extension of time for activities conducted by the State, Managed Care Organizations (MCOs), and/or specialized mental health and substance use disorder (SUD) programs, due to the social distancing needed to reduce the spread of COVID-19 and to allow State, MCO, and behavioral health resources to prioritize COVID-19 response efforts including but not necessarily limited to:

To reduce exposure for agency employees and potential vendors, BMS seeks to delay the implementation of the Electronic Visit Verification (EVV) procurement and the vendor award for the duration of the emergency with implementation of services occurring after January 1, 2021, without out an FMAP reduction. This request will ensure bidders can arrange oral presentations via teleconference and can provide for an extended roll out of services. Such services will be coordinated with providers of in-home care who are already struggling with providing quality in-home services while they attempt to reduce exposure and transmission of the virus.

During this public health emergency, the State is requesting a waiver of public notice requirements for State plan amendments related to the pandemic for State plan amendments that provide or increase beneficiary access to items and services related to COVID-19 (such as cost-sharing waivers, payment rate increases, or amendments to alternative benefit plans adding services or providers) and would not be a restriction or limitation on payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date related to COVID-19. BMS requests a waiver of the following reporting requirements, which include, but are not limited to:

- Reporting deadlines for all federal early and periodic screening, diagnostic and treatment (EPSDT) reports that become due during the disaster declaration extended to no later than the sixty (60) days after the end of federal disaster declaration period.
- Reporting deadlines in any Medicaid grant or demonstration waiver, including, but not limited to:
 - For the Maternal Opioid Misuse Services (MOMS) Grant, an extension of the following reports for as long as the COVID-19 National Emergency Declaration remains effective:
 - Quarterly reports
 - Quarterly State Plan Amendment timeline

- Quarterly updated Model Implementation Plan
 - Implementation incentive plan for year 2
 - Managed Care plan participation documentation member consent form
 - Capacity to link mother-baby dyads
 - Driver Diagram
 - Non-competing continuation application
- For the **Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Planning Grant**, the ongoing COVID-19 pandemic will significantly impact DHHR's ability to complete planning grant activities within the original eighteen (18) month planning grant time frame. Acting in accordance with CDC guidelines and local directives, the majority of our project team will be teleworking for the foreseeable future. The COVID-19 pandemic has also shifted local and national priorities in a way that will hinder our ability to meaningfully engage with key stakeholders both locally and nationally. Therefore, DHHR **requests an extension of the planning grant timeframe** for as long as the COVID-19 National Emergency Declaration remains effective. We are not requesting a change to the overall planning grant scope of activities or the agreed upon-budget. The following planning grant activities will be impacted by the pandemic:
- Regularly convening workgroups related to telehealth, Centers of Excellence in addiction treatment, provider capacity, and SUD Needs Assessment;
 - Providing training and technical assistance to identified treatment providers;
 - On-boarding and training data analysts to assist with the SUD needs assessment;
 - Conducting site visits to other states' Centers of Excellence in Addiction Treatment;
 - Developing a West Virginia Centers of Excellence white paper;
 - Convening six (6) regional meetings across the State to obtain community input, which impacts the ability to complete a comprehensive SUD needs assessment;
 - Developing and implementing a systematic evaluation of activities conducted pursuant to this planning grant;
 - Conducting a landscape review of reimbursement practices in other states; and,
 - Monthly and quarterly reporting, both in written and telephonic form, as well as Groupsite participation expectations.
- For the Section 1115 demonstration waiver "**Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders**", DHHR **requests an extension of the due dates** for all reporting including, but not limited to monthly and quarterly monitoring and budget neutrality reports for the duration of the emergency.

Managed Care

The State also requests the authority to **modify certain performance deadlines and timetables** applicable to the State's administration of its Medicaid managed care program during the period of the emergency declaration. To ensure the State's efficient operation of the managed care program and to lessen the administrative burden on the Medicaid delivery system (including managed care entities and healthcare providers), the State requests **adjustment of the following performance elements or reporting timetables** required under the federal law and 42 CFR §438 during the declared emergency period and any extensions thereof, including, but not limited to:

- The waiver of the timeframe required for submission to CMS of contracts under 42 CFR § 438.3(a). BMS requests this waiver to allow MCOs flexibility regarding obtaining, in a timely manner, required contract signatures, which requires face-to-face interactions at board meetings.
- The waiver of plan requirements to meet **network adequacy** standards required under 42 CFR § 438.68 and timely access standards for routine services required under 42 CFR § 438.206(c). This waiver is necessary to ensure health care providers are able to provide necessary and timely care to beneficiaries experiencing symptoms related to COVID-19.
- Modification of the timeframe for submission of annual network certification to CMS required under 42 CFR § 438.207. BMS requests an extension of its annual network certification for the duration of the emergency.
- Flexibility/modification of the timeframe for submission of monthly T-MSIS reporting.
- Waiver regarding the timely completion of external quality review (EQR) activities required under 42 CFR § 438.358, including all site visits performed by the EQR organizations and required network validation activities. BMS requests this waiver/flexibility to limit site visit requirements as well as to allow administrative relief for MCOs during the period of the emergency. BMS requests suspension of EQR activities for the duration of the emergency.
- Modification to the timeframe for submitting to CMS and publicly posting the EQR technical report required under 42 CFR §438.364(c)(2)(1). BMS requests to extend the timeline for the duration of the emergency.
- Modification of the timeframe for submission of BMS' qualify strategy report required under 42 CFR §438.340. BMS requests an extension for the duration of the emergency
 - The annual report of each managed care program administered by the State as required under 42 CFR §438.66(e)(1) from no later than 180 days after the SFY20 contract year to no later than 240 days after the SFY20 contract year.
 - To the extent any new managed care contracts and/or rates are implemented, the contract and rate certifications required under 42 CFR §438.3(a) requiring submission of the managed care to CMS ninety (90) days prior, to no later than twenty (20) days prior to the effective date of such contract(s) or rate(s).
 - Medical loss ratio reporting deadlines required under 42 CFR §438.8(k) that otherwise become due during the disaster declaration period to be submitted no later than sixty (60) days after the end of the federal disaster declaration period.

Dan Belnap, State Lead
March 23, 2020

- Quarterly drug utilization data collection deadlines under 42 CFR §438.3(s)(2) that become due during the declared disaster period to no later than sixty (60) days after the end of the disaster declaration period.
- Extension of new or pending enrollee initial screening deadlines under 42 CFR §438.208(b)(3) to no later than one hundred (120) days of the effective date of enrollment.
- Extension of providers' deadline to return overpayments to the managed care entity under 42 CFR §438.608(d)(2) that become due during the declared disaster period to no later than sixty (60) days after the end of disaster declaration period.
- The extension of timely filing guidelines for providers that do not submit EDI claims for managed care organizations and the State's fiscal agent.
- The reporting requirements under 42 CFR §438.3 and 42 CFR Subpart K regarding the parity in mental health and SUD benefits Compliance Plan to be submitted sixty (60) days after the end of the federal disaster declaration period.
- To facilitate programmatic expansions, this request includes flexibility to waive the requirement to conduct procedural and system readiness reviews within 90-days of contract awards to managed care organizations.

Unless stated otherwise, West Virginia requests that these waivers automatically extend for length of the National Emergency declaration and regardless of the implementation of a state emergency preparedness plan. We appreciate your assistance and look forward to working together to achieve our mutual goal of protecting the health and well-being of West Virginians. If you would like to discuss this request, please contact Cindy Beane at Cynthia.E.Beane@wv.gov.

Sincerely,

/s/Cynthia Beane

Cynthia Beane, MSW, LCSW
Commissioner

Cc: Fran McCollough, CMS
Gary Knight, CMS
Bill Crouch, Cabinet Secretary, DHHR
Jeremiah Samples, Deputy Secretary, DHHR