MSHN
Mid-State Health Network

Coronavirus Disease 2019 (COVID-19)
Frequently Ask Questions
As of April 2, 2020

Given how rapidly things are unfolding, we recommend you follow guidance from the Centers for Disease Control and Prevention (CDC). You can sign up for CDC updates at the bottom of the CDC website here.

As questions are submitted to coronavirus@midstatehealthnetwork.org, MSHN will attempt at providing you the most current information and guidance through updates in constant contact and "Frequently Asked Questions". MSHN is diligently working and communicating with MDHHS seeking clarification regarding state requirements.

NEW **A table of contents has now been included in the FAQ to assist and direct providers to applicable sections.**

The table of contents is still organized by General Guidance, Community Mental Health Service Programs, and Substance Abuse Prevention and Treatment. New questions are marked with ***NEW*** to highlight any recent additions.

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GENERAL GUIDANCE

Verbal Consent

QUESTION: Can providers accept verbal consent for services from a parent, legal representative, or guardian during the COVID-19 emergency?

Answer: Yes. Per Center for Disease Control and Prevention (CDC) and state recommendations for social distancing to slow the spread of COVID-19, the state is allowing greater flexibility related to telemedicine audio/ visual requirements to the protect the health and welfare of beneficiaries and providers while maintaining access to vital services during the COVID-19 pandemic.

As such, the Office of Civil Rights has indicated they will not pursue violations of HIPAA during this emergency. Additionally, the Office of Recipient Rights (ORR) and Behavioral Health and Developmental Disabilities Administration (BHDDA) will temporarily suspend enforcement of the written consent requirements to ensure that services are not being withheld or limited due to the inability to get a written consent. CMHSP and contract providers should make use of alternatives to face to face encounters that can be used to obtain written consent, including but not limited to, fax, email or picture of signed document sent via text or email. All attempts to obtain written consent should be documented, along with the verbal consent, in the recipient's record.

Footnote: MCL 330.1100a Definitions; A to E. (19) "Consent" means a written agreement executed by a recipient, a minor recipient's parent, a recipient's legal representative with authority to execute a consent, or a full or limited guardian authorized under the estates and protected individuals code, 1998 PA 386, MCL 700.1101 to 700.8206, with the authority to consent, or a verbal agreement of a recipient that is witnessed and documented by an individual other than the individual providing treatment.

QUESTION: Does this MDHHS directive apply to all consents or just the Consent to Treatment? It reads as though this would include the Releases of Information, Medication Consent, IPOS Signature Page as well.

Answer: Based on the guidance provided above regarding consents, it is the interpretation by MSHN that the acceptance of verbal consents applies to all types of consent during this time of state of emergency as long it is documented in the beneficiaries file that attempts to obtain written consent could not be utilized and verbal consent was obtained. In addition, the Office of Civil Rights (OCR) announced in the Notification of Enforcement Discretion for Telehealth Remote Communications located here, during the COVID-19 Nationwide Public Health Emergency, that a covered health care providers will not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

Adverse Benefit Determinations

QUESTION: Should providers be sending out Adverse Benefit Determinations (Advanced Notices/Adequate Notices) to those clients that are not able to participate in services because of the restrictions?

ANSWER: In a phone call between PIHPs and MDHHS on 3/18/20, MDHHS indicated that it intends to submit an "1135 Waiver" that in part addresses this question. An 1135 waiver is more inclusive than behavioral health and includes broad healthcare delivery system adjustments during a public emergency. MDHHS reported that it is pursuing a waiver and restructuring of the system for appeals and fair hearings, including notices.

Providers are advised that as long as the service reduction/alteration affects all clients served and is well publicized that some services are being suspended on a temporary basis, then adverse benefit determinations are not expected in this situation.

Until official written guidance is promulgated by MDHHS, please continue to provide up-to-date information to consumers on the status of services within your agency by any reasonable means available (i.e., postings to web sites, mass emails, social media posts, etc.). If your agency does not send out adverse benefit determination notices at this time, please be advised that you may be required to do so once official guidance is received from MDHHS.

Provider Network Service Limitations

QUESTION: Will information be disseminated regarding status updates of providers/programs that are limiting services?

ANSWER: MSHN is tracking provider network status as reported by SAPT Provider and CMHSP Provider Network. Information will be shared on the MSHN Coronavirus website as well as updated on the Provider Directory (via NOT accepting new patients).

Training: CPR/First Aid

QUESTION: Will MDHHS provide an extension of current CPR/First Aid cards per update from the American Heart Association?

ANSWER: This guidance can be accepted. Recommend documenting in files appropriately for those impacted.

UPDATE: Additionally, the American Red Cross issued guidance for training as well as added flexibility to accommodate Certificate Holders and Instructors.

NEW **QUESTION: Recently the Department of Licensing and Regulatory Affairs issued a statement regarding CPR/First Aid trainings; they took a position on both new and current employees. Will these exceptions also apply to those direct care staff / aids providing CLS and Respite services in the community or in unlicensed residential settings?**

ANSWER: MSHN supports applying this guidance to any/all provider types for CPR/First Aid Training. Please document reasons for delays in required f2f training/recertification in personnel files.

Personal Protective Equipment

QUESTION: Providers have limited or no supply of Personal Protective Equipment (PPE). Does MSHN have a recommendation for supply or other PPE?

ANSWER: Please follow CDC and MDHHS guidance relating to the taking of all health and safety precautions. CDC released Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies which contains additional guidance due to the PPE shortage, as well as Use of PPE FAQ and Interim Guidance for Infection Prevention & Control in Healthcare Settings.

Health and Safety Precautions

UPDATE: Governor Whitmer Orders Temporary Restrictions on Entry into Care Facilities:

Governor Gretchen Whitmer has signed Executive Order 2020-6 to impose temporary restrictions on entry into health care facilities, residential care facilities, congregate care facilities, and juvenile justice facilities. The Governor also ordered public bodies to postpone public meetings and to facilitate remote participation in the meetings that do occur.

Under Executive Order 2020-6, beginning Saturday, March 14, all health care facilities, residential care facilities, congregate care facilities, and juvenile justice facilities must prohibit any visitors that are not necessary for medical care, support of activities of daily living like bathing or eating, or that are not visiting under exigent circumstances. Additionally, beginning as soon as possible but no later than Monday, March 16 at 9:00am, these facilities must assess for COVID-19 symptoms and risk factors for all individuals not under their care who are seeking entry into their facilities. The facilities must deny entry to any individual with these symptoms or risk factors. These restrictions will remain in place until April 5, 2020 at 5:00pm.

QUESTION: Do we limit provider visits in the community or only if client or member of family is presenting with symptoms?

ANSWER: Please follow CDC and MDHHS guidance relating to the taking of all health and safety precautions. In the interest of social distancing which can reduce individuals' chance of infection and slow the spread of the virus, MSHN recommends limiting exposure in the community as much as possible. Therefore, if it is an option to do visits in the community by phone, Skype, FaceTime, etc., that is recommended. If that's not possible but the meeting in the community is non-essential and can be rescheduled, please reschedule. If activities in the community are unavoidable, please consider alternative activities such as outdoor activities that do not involve close contact with others or where it's easier to maintain a 3-6 feet distance from others.

UPDATE:
MDHHS Released guidance on 3.25.20 - #20-01: Essential Behavioral Health Services and Stay Home Safe Executive Order 2020-21 in the COVID-19 Context. Considerations should be given for when a service should be provided via telepractice in lieu of face to face to protect all individuals. This should be documented in the record.

If individual visits are deemed necessary to individuals who live independently, direct care workers should engage in daily telephonic wellness checks, video calls, or telehealth appointments. If clinically necessary, direct care workers should engage with clients face-to-face only after:

- Attempted phone contact. The direct caregiver should try to reach the client by phone and receive an assurance that the client does not need support to sustain life.
- Attempted use of client network. If the direct caregiver cannot reach the client, or if the client is reached and is need of help, the direct caregiver should attempt to reach all known members of the client's informal caregiver network. The caregiver should seek assurance that a member of the network will contact the client and, if necessary, visit the client to sustain life, provided the friend or family member is healthy, not in a group at high-risk of COVID-19, and otherwise practicing social distancing. Such a friend or family member can conduct caregiver visits to one individual with less risk of repeatedly transmitting COVID-19 than a direct care worker.
- The direct care worker may work with members of the client's network to establish a regular cadence of visits which can be conducted by personal friends, family, or other contacts, not direct care workers.

QUESTION: In the context of the COVID-19 pandemic, how do we safely maintain clinical operations and ensure those seeking treatment have access to services?

ANSWER: In addition to information from the CDC, here are some concrete steps and precautions offered by MSHN's Medical Director:

- Designate a time to meet with your staff to educate them on COVID-19 and discuss what they may need to do to prepare.
- Social distancing is recommended and involves keeping a 3-6 feet distance from others and avoidance of public gatherings.
- Create a process to screen all incoming clients. This can include:
    1. Has there been recent travel history to China, Italy, S. Korea, or Iran?
    2. Has there been recent contacts with travelers to those areas?
    3. If the answer is "yes" but no symptoms are present, advise the individual that a 14-day waiting period is necessary to rule out the emergence of symptoms.
    4. Reassure the individual seeking treatment know that he/she will be rescheduled once medically cleared.
- If at intake, they report or display symptoms like fever, coughing, and shortness of breath, do not admit them. Please help that individual with a warm hand off/phone call to their primary care provider or nearest Urgent Care or Emergency Department and follow their direction.
- Guide people already in outpatient services to disclose if, since their last visit, there has been any change in their health condition or any exposure to travel or people who traveled in high-risk areas.
- Prominently post reminders to share any changes in health status.
- Implement CDC recommended preventive protections in both residential and outpatient settings. See here for additional prevention tips.
- Communicate and prominently post preventive measures about handwashing, disinfecting high-touch areas, maintaining distance of 3-6 feet, cover nose and mouth when sneezing or coughing, avoid touching the face, etc. (see CDC resources to print here).
- Advise clients and employees with any signs of illness (fever, cough, shortness of breath) to stay at home and reach out to their primary care provider or Urgent Care.
- If in-person groups are unavoidable, try to reduce the group size so as to maintain as much space as possible between individuals (6 feet or more).

- If symptoms appear mid-episode of outpatient care, reschedule any non-urgent outpatient visits and help them with a warm hand off/phone call to their primary care provider. Let them know treatment will be rescheduled once the individual has been cleared medically.
- If symptoms appear mid-episode of residential care, residential providers should:
    1. Remove the individual from contact with others and do a warm hand-off/phone call to their primary care provider and follow the PCP's direction.
    2. In the absence of an identified PCP, assist the individual in contacting Urgent Care or the local Emergency Department for direction.
    3. If an unanticipated/premature discharge is necessary, let the individual know that treatment will be rescheduled/continued once the individual has been cleared medically.
    4. Seek input from the Health Department for directions regarding how to handle those who have had contact with that individual.

Throughout this process, please remind the person seeking treatment or in treatment that you are there to assist with their recovery once this medical crisis has passed.

Residential Treatment with Symptomatic Clients

QUESTION: If a person becomes symptomatic after they enter residential treatment, should the facility stop all new admissions and quarantine the whole facility for 14 days?

ANSWER: Dr. Alavi (MSHN's Medical Director) advises working with the local health department and follow their recommendations regarding quarantine. If they advise that the entire house/facility should be quarantined with no new admissions, then it would be appropriate to follow that recommendation. If they think the particular individual can be safely quarantined in a bedroom area away from the rest of the group, then it may be appropriate to continue with new admissions but the provider would want to follow the directives of the local health department.

Telehealth and Telephonic Practices

QUESTION: Can telehealth be used to provide treatment services to help with social distancing and to limit risk of exposure for all involved?

UPDATED ANSWER (4/1/2020): MDHHS has released several policy statements covering telephonic and telehealth (Video/Audio) practices. These can be found on the MSHN Web Site at this link. Posted documents include:

- MDHHS Telepractice Memo dated March 19 and April 1, 2020
- Revised COVID-19 Encounter Code (This code chart should be used in conjunction with the April 1, 2020 Telepractice Memo)
- MSA Policy 20-09 – General Telemedicine Changes
- MSA Policy 20-12 – COVID 19 Response: Relaxing Face-To-Face (Service Delivery) Requirements
- MSA Policy 20-13 – COVID 19 Response: Telemedicine Policy Expansion; PIHP/CMHSP Implications, issued March 20, 2020

Questions about these MDHHS document should be directed to: MDHHS-ProviderQualificationCode@michigan.gov

CLARIFICATION: CMS guidance indicates that applications, such as FaceTime and Skype are permitted. MDHHS/MSA Policy 20-12 seems to contradict federal policy and obtained official clarification from MDHHS/MSA as follows:

Federal regulations supersede state regulations, so in the case of HIPAA, please follow the federal guidance to relaxing HIPAA standards.

MDHHS Policy 20-13 allows for telephonic (audio) only services and includes documentation requirements for telephonic (audio) only services.

> **MSHN REMI documentation:** When providing an allowable telemedicine service using audio (telephonic) only, please include the following information in the 'Notes' field when submitting claims – "Service provided via telephone".

NOTE: Previous guidance provided by MSHN is rescinded effective 03/18/2020.

Telephonic: Billing and Third Party

QUESTION: Will Medicaid cover telephone only services provided to Medicaid beneficiaries with 3rd party insurance when then the 3rd party requires audio and visual under the Covid-19 expansion?

Example, an elderly Medicare/Medicaid consumer receives outpatient individual therapy over the telephone because he/she does not have a computer, smart phone or the knowledge to use such applications with audio/video capability.

ANSWER: Medicare and other third-party payers have relaxed their telehealth rules during the Covid-19 crisis. Providers should follow the billing rules of the consumer's primary insurance and obtain an Explanation of Benefits (EOB) form which outlines reasons for payment or non-payment. The EOB form should accompany the claim to MSHN for further consideration/reimbursement.

Provider Qualifications

Licensing

QUESTION: Can you offer guidance on social worker licenses that may expire on 4/30/20.

ANSWER: Based with the most recent executive orders from the Governor:

- Effective immediately and continuing through April 14, 2020 at 11:59 pm, LARA may renew a license to practice under Part 170, 172, 175, 177, or 187 of the Public Health Code, 1978 PA 368, as amended, regardless of whether the licensee has satisfied the continuing education requirement applicable to their license.
- Effective immediately and continuing through April 14, 2020 at 11:59 pm, LARA may recognize hours worked responding to the COVID-19 emergency as hours toward continuing education courses or programs required for licensure.

QUESTION: Can you offer guidance for Temporary Limited Licensees or Limited Licensees with Nearing Expiration Dates:

ANSWER: In accordance with Executive Order 2020-30, for individuals with a temporary limited license or a limited license that expires and whose exams were canceled due to COVID-19, LARA will allow these licenses to remain valid for an additional 6-month term in order for applicants to sit for their exams and complete remaining requirements for limited or full licensure.

COMMUNITY MENTAL HEALTH SERVICE PROGRAMS

CONGREGATE SERVCIES

QUESTION: PIHPs and CMHSPs received the communication below from the CMHAM on 3/13/20. Can you please confirm that the following reflects the position of MDHHS?

ANSWER: The below information is consistent with the MDHHS position.
CLOSING CONGREGATE SERVICES: In discussions with MDHHS leadership, they have determined that, given the fact that avoiding crowds and ensuring social distance are key methods for preventing the spread of COVID-19, temporarily closing clubhouses (PSR), drop-in centers, site-based day programming (CLS, PC, Skill building), and similar services would be supported by MDHHS. Other services, provided via telehealth, could be/should be provided to support those persons who would normally be served at these congregate settings, during the period in which they are closed.

APPLIED BEHAVIOR ANALYSIS (ABA)

ABA: Telehealth

QUESTION: How will MSHN deal with network requests for ABA tele-practice options to mitigate risk?

ANSWER: MSHN shall approve the case via the WSA without any additional amendments to the IPOS or the IPOS tab being required. Please note in the comment section of the tele-practice tab, "*mitigation strategy for COVI-19*."

UPDATED 3/18/2020: Optum will run a script in the WSA AUT application to auto-generate a blanket "COVID-19 prior authorization" for Family Training and Observation & Direction for all enrolled beneficiaries for the time period of March 1, 2020 through March 1, 2021. This will pre-populate a row in the telepractice tab for the allowed use of this option if they choose to use it during this period of time. Additional details will be forthcoming as they build and test.

Please advise your WSA users that they will not need to manually enter individual authorization requests to address COVID-19. This is being built today and is earmarked for release by next Wednesday, at the regularly schedule break fix. If the programmers are able to do it sooner, I will let you know.

UPDATED ANSWER: (4/1/2020): MDHHS has released several policy statements covering telephonic and telehealth (Video/Audio) practices. These can be found on the MSHN Web Site at this link. Posted documents include:

- MDHHS Telepractice Memo dated April 1, 2020

- Revised COVID-19 Encounter Code (This code chart should be used in conjunction with the April 1, 2020 Telepractice Memo)
- MSA Policy 20-09 – General Telemedicine Changes
- MSA Policy 20-12 – COVID 19 Response: Relaxing Face-To-Face (Service Delivery) Requirements

***ADDITION* (3/20/2020)**:

- MSA Policy 20-13-Telemedicine Policy Expansion
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html (federal guidance on HIPAA compliance supersedes state guidance-confirmed).

Questions about these MDHHS document should be directed to: MDHHS-ProviderQualificationCode@michigan.gov

QUESTION: What are some good resources to assist ABA providers in understanding the rules around telehealth?

ANSWER (FROM MDHHS): https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

QUESTION: Can the Autism annual evaluations be postponed for 30 days due to the COVID-19 social distancing recommendations?

ANSWER (FROM MDHHS): BHDDA has waived the prior authorization of telepractice for ABA in response to this virus. Additionally, BHDDA is expanding telehealth options and pursuing approval ***to waive current evaluation requirements*** and other barriers identified for the Medicaid ABA Benefit Program through the 1135 authority.

QUESTION: What about the Autism Re-evaluations that are performed at CMH, particularly those that will expire soon, that are necessary for the client to continue with ABA Therapy services? Are the children to lose their services or is there an extension in place? Or are we to consider that it is medical necessity to perform?

UPDATED ANSWER (4/1/2020): MSHN is still awaiting further guidance from MDHHS regarding its 1135 Waiver request from CMS. Also, please see the following policy statements from MDHHS that address telemedicine practices during a public health emergency:

MDHHS has released several policy statements covering telephonic and telehealth (Video/Audio) practices. These can be found on the MSHN Web Site at this link. Posted documents include:

- MDHHS Telepractice Memo dated April 1, 2020
- Revised COVID-19 Encounter Code (This code chart should be used in conjunction with the April 1, 2020 Telepractice Memo)

- MSA Policy 20-09 – General Telemedicine Changes
- MSA Policy 20-12 – COVID 19 Response: Relaxing Face-To-Face (Service Delivery) Requirements
- MSA Policy 20-13-Telemedicine Policy Expansion
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html (federal guidance on HIPAA compliance supersedes state guidance-confirmed)

Questions about these MDHHS document should be directed to: MDHHS-ProviderQualificationCode@michigan.gov

QUESTION: Our ABA providers are indicating that they had been given approval from MDHHS in Michigan to provide all ABA services through tele-health, including direct ABA therapy, have there been changes that allow this?

UPDATED ANSWER (4/1/2020): Please see the MDHHS policy bulletins below that update which ABA services can be provided via telehealth. Please see the "COVID-19 Encounter Code Chart for codes currently available under telehealth and those services now allowable under telehealth during the public health crisis. The green rows reflect currently allowable telehealth practices and can also now be provided through the means in the COVID-19 face-to-face guidance. The yellow rows reflect currently unallowable telehealth practices that can now be provided through telehealth practices and through the means in COVID-19 face-to-face guidance. This now includes ABA adaptive behavior treatment (97153) when this service only requires verbal cueing or direction and not physical (hands on) prompting, guiding, and/or training. The white rows are not available for any type of telehealth practices.

MDHHS has released several policy statements covering telephonic and telehealth (Video/Audio) practices. These can be found on the MSHN Web Site at this link. Posted documents include:

- MDHHS Telepractice Memo dated April 1, 2020
- Revised COVID-19 Encounter Code (This code chart should be used in conjunction with the April 1, 2020 Telepractice Memo)
- MSA Policy 20-09 – General Telemedicine Changes
- MSA Policy 20-12 – COVID 19 Response: Relaxing Face-To-Face (Service Delivery) Requirements
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Questions about these MDHHS document should be directed to: MDHHS-ProviderQualificationCode@michigan.gov

QUESTION: Some CMHs are still mandating HIPAA approved technology, despite DHHS lifting these restrictions to open telehealth up to methods such as Facetime and Skype. Are MDHHS and the PIHPs following the HHS bulletin?

ANSWER: Providers are encouraged to follow written guidance provided by CMS and/or MDHHS and to stay connected with the administration of the local CMHSP about available platforms. MSA Bulletin 20-12 notes

that providers may use telephonic, telemedicine, and video technology commonly available on smart phones for program functions that require in-person communication so long as they meet HIPAA compliance standards and the beneficiary or legal representative consents to the method. Providers are encouraged to notify individuals that any third-party applications potentially introduce privacy risks and providers should enable all available encryption and privacy modes when using such applications. As long as the video feed is not stored on the device, it is sufficiently secure under the federal/CMS waiver of HIPAA compliance.

QUESTION: Can you clarify if the phone is okay for families without WIFI or who can't use the technology for one reason or another?

ANSWER: Per MSA 20-12, providers may use telephone for program functions that require in-person communication. This include initial assessments, care planning meetings, home visits, case management, and provider assessment and monitoring. If the beneficiary is unable to communicate over the phone, these activities may be completed with a guardian or other representative of the beneficiary that is familiar with their needs.

QUESTION: Signatures on treatment plans and consents the MSA bulletin seems to waive this requirement in the interim is that accurate? Should we send finalized plans to our CMHSPs unsigned to stay on schedule? Consents as well, we had been requiring a signature on the consent form for telehealth from families, is verbal consent acceptable?

ANSWER: MSA 20-12 states that in lieu of the required written consent or beneficiary signatures, verbal permission may be obtained and signatures to follow at the next in-person opportunity. It is MSHN's position that this should include most documents. Providers should use their judgment regarding the risk to beneficiaries and employees relative to the need for in-person communication, especially with beneficiaries that have complex care needs.

ABA: Documenting Inactivity

QUESTION: Should we be adding inactivity for families that are choosing to suspend services for the coming weeks?

ANSWER: If you know this data and have the capacity to enter, you may. If you don't have the data or capacity, you can always enter it in later.

ABA: WSA Reporting

QUESTION: Can we please get direction on how to handle reporting in the WSA when family only wants Family Guidance? Do we need to end date ABA service and upload a new addendum with just FG box checked?

ANSWER: Add language in the comment section in the WSA to signify the need for the change in services due to COVID-19 if it is not possible (advisable) to do a PCP addendum. They should not be made inactive in the WSA.

ABA: Health and Safety Precautions

QUESTION: For in-person/higher intensity services, how should providers be dealing with contact in these higher intensity and ongoing services situations?

ANSWER: Please follow CDC and MDHHS guidance relating to the taking of all health and safety precautions. MSHN and the CMHSPs have established a Four-Tier System developed for response based on current level of outbreak and providing services to beneficiaries in the specific county area. CMHSPs are also implementing agency-specific plans. MSHN is also recommending following social distancing protocols to reduce the possibility of virus transmission.

QUESTION: Per MDHHS infection control guidelines "general use of Personal Protection Equipment (PPE) is NOT required if working with an individual who has not been identified as a person under investigation or having been found positive for COVID-19." However, we have received requests from payors and/or families asking for our staff (i.e. Behavior Technicians) to use PPE when performing services with their families in-home and center based. Can you please advise how to bill these incremental expenses, assuming they are acceptable?

ANSWER: Please review the ABA key considerations and regional guidance. There first must be a clear determination of when to deliver a face-to-face in person encounter versus a virtual encounter. Assuming f2f services is essential and appropriate, providers/CMHSPs should negotiate method and manner of reimbursement of necessary supplies.

STATUS OF WAIVER REQUIREMENTS

QUESTION: With the current COVID-19 situation, some questions have arisen in our region regarding requirements regarding waiver programs and the Autism benefit.

ANSWER (FROM MDHHS): MDHHS is currently pursuing all available options to address this through federally approved channels. These channels includes flexibilities that enable states to waive prior authorization requirements to remove barriers to needed services, streamline provider enrollment processes to ensure access to care for beneficiaries, allow care to be provided in alternative settings in the event a facility is evacuated to an unlicensed facility, suspend certain nursing home screening requirements to provide necessary administrative relief, and extend deadlines for appeals and state fair hearing requests. These flexibilities will enable the state to focus its resources on combatting this outbreak and provide the best possible care to Medicaid beneficiaries in Michigan.

- MI Appendix K for all three 1915(c) waivers (CWP, HSW, and SEDW)
- MI is pursing approval to waive certain requirements in Medicaid, and CHIP under Section 1135 authority.
  - This authority would impact all the behavioral health covered state plan services, including EPSDT/ABA services.

HOME AND COMMUNITY BASED SERVICES (HCBS)

MDHHS Issues Guidance on HCBS:

- MDHHS received questions regarding restrictions based on COVID-19 concerns and how the HCBS rule impacts the ability of providers to be both HCBS compliant and implement restrictions. When a provider is implementing restrictions in a way that is consistent with the guidance being provided by the CDC, CMS, and State of Michigan related to the COVID-19 virus and social distancing, or other identified mitigation strategies recommendations or executive orders, a note that references current COVID-19 restrictions as a result of Governor Whitmer's executive order should be placed in each individuals record with a start date and updated with an end date when known. If issues arise on an individual basis, please feel free to contact MDHHS.

- MDHHS encourages all providers to follow CDC guidelines related to universal precautions and all other relevant guidance.

- MDHHS continues to communicate with CMS regarding our waivers and HCBS standards and will share any new information with the field as they learn it.

- MDHHS MSU partners have suspended onsite face to face setting reviews in order to comply with federal and state guidance. The reviews will continue with evidence being gathered through document reviews utilizing secure emails or through the FTP. As additional information related to this process is developed, they will continue to share it with the field.

- In regard to ongoing corrective action plan (CAP) work MDHHS is discussing the issue internally and welcomes ideas about how we can creatively gather the information needed. Included for consideration are the use of technology to provide photographic evidence and/or other remote gathering of evidence. Please provide us with any thoughts you have related to this process and how to most efficiently move forward.

- Please refer to the MDHHS L letter and BHDDA supplemental policy letter issued today located here. Additional information regarding face to face requirements will be issued in the future.

HCBS: Health and Safety Precautions

QUESTION: We are trying to practice social distancing as recommended by the state. We are offering alternative activities, such as outdoor activities that do not involve much contact with others. We are also wanting to make sure we can abide by the HCBS requirements as much as possible. What your recommendations be to those questions, specifically regarding community inclusion, and how to best to document these concerns during this time? During the Coronavirus outbreak, if consumers for health and safety reasons do not have community inclusionary outings will this be an issue?

ANSWER: MSHN is seeking further feedback from MDHHS regarding HCBS-requirements. Please follow CDC and MDHHS guidance relating to the taking of all health and safety precautions. MSHN and the CMHSPs have established a Four-Tier System developed for response based on current level of outbreak and providing services to beneficiaries in the specific county area. CMHSPs are also implementing agency-specific plans. MSHN is also recommending following social distancing protocols to reduce the possibility of virus transmission.

QUESTION: Can you provide guidance to providers on how we should be handling HCBS requirements during this time-we intend to follow these mitigation strategies and stop unnecessary community outings for our residents and discouraging visitors based on the guidelines CMS sent out for nursing facilities.

ANSWER: MSHN is seeking further feedback from MDHHS regarding HCBS-requirements. Please follow CDC and MDHHS guidance relating to the taking of all health and safety precautions. MSHN and the CMHSPs have established a Four-Tier System developed for response based on current level of outbreak and providing services to beneficiaries in the specific county area. CMHSPs are also implementing agency-specific plans. MSHN is also recommending following social distancing protocols to reduce the possibility of virus transmission.

QUESTION: If we have a situation (regardless of the illness-whether influenza or COVID-19), that we would follow any standard restrictions as laid forth by the CDC (self-quarantine, limiting visitors such a hospital does). Is this correct?

ANSWER: Please follow CDC and MDHHS guidance relating to the taking of all health and safety precautions. MSHN and the CMHSPs have established a Four-Tier System developed for response based on current level of outbreak and providing services to beneficiaries in the specific county area. CMHSPs are also implementing agency-specific plans. MSHN is also recommending following social distancing protocols to reduce the possibility of virus transmission.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE WAIVER (SEDW)

QUESTION: When we have a youth as a court ward and Mary's name is printed on the Family Choice Assurance, do we also need the foster care worker and/or foster parent to sign? We are trying to do as much as we can remotely but getting signatures has been a barrier.

ANSWER: For MCI Permanent State Wards, Mary Chaliman's signature is the only signature needed on the FCA. This is always true, not just now amid this situation.

In addition, for SEDW applications/recerts that require a parent/legal guardian's signature on the FCA, we are temporarily allowing the following:

Verbal consent is permitted right now. Please note the parent provided verbal consent and the child's date of birth and last 4 digits of the child's social security number on the Family Choice Assurance form. Please also make a comment regarding the verbal consent under the Comments tab. Lastly, you will need to acquire the parent's signature during the next face-to-face contact and provide us with a copy of the signed Family Choice Assurance form.

RESPITE SERVICES

RESPITE: APPEALS

QUESTION: We have gotten an appeal for Respite services. This is on the non-essential list for BH services. Is there any guidance for approaching these appeals?

ANSWER: Respite services require a face-to-face interaction and cannot be performed via telehealth methods. The communication #20-01 (Stay Home Stay Safe) identifies all behavioral health services as essential services and states they must continue to be provided in homes, residential settings and clinical settings if they cannot be reasonably performed through telehealth methods and are necessary to sustain and protect life. In addition, Home-based or clinic-based services are necessary to sustain and protect life if, based on a provider's good faith clinical judgment, are necessary for the individual to remain in the least restrictive environment, are required for assistance with activities of daily living, instrumental activities of daily living (IADLs), be sustained on life preserving medication, as well as those services necessary to maintain behavioral or psychiatric stability.

The Medicaid Provider Manual (Section 17.3.1I) defines respite care services as those that are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.

Based on this document (communication #20-01), I would say that respite does not meet the criteria defined as one to sustain or protect life. Respite is intended as a means to provide the caregiver time away for them to perform other tasks or simply to get a break. It is an important service, but I would not deem it one to sustain or protect life.

RESIDENTIAL SERVICES

RESIDENTIAL: ACCEPTING INDIVIDUALS

NEW **QUESTION: We are hearing from some AFC providers that they have had the State tell them they cannot accept anyone into their homes during this COVID period. Has there been some information sent to residential providers from the state that is different than making sure consumers are isolated for the first 14 days in order to assure they don't have coronavirus?**

ANSWER: If this pertains to an individual returning from a hospitalization and is ready to be discharged and the AFC or HFA has proper supplies and staff to meet the needs of the resident when discharged, then the facility is required to take the resident as they must be able to return to their home. Facilities should be asking questions of the hospital such as the following before the hospital discharges the resident back to their facility.

- Does the resident meet criteria outlined in the CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalization Patients with COVID-19?
- Has the patient gone at least 3 days (72 hours) fever free without the use of fever reducing medications and demonstrates an improvement in respiratory symptoms (cough, shortness of breath)? If no, then the resident is not ready to be discharged from the hospital.
- Does the facility have the needed PPE or medical staff available to meet the resident's needs?

Hospitals should provide guidance on any precautions (if any) that the facility should take to protect staff and other residents. If the hospital is recommending staff use PPE (like gloves, masks, etc.) and the facility does not have any nor can they get any, they should discuss that with the hospital discharge planner to see if they can assist the facility in getting needed items before the resident is discharged.

As the question relates to new admission of new residents: per the Department of Licensing and Regulatory Affairs (LARA) FAQ, dated 3/31/2020, to date, the state has not banned new admissions. The facility should do their own risk assessment and conduct a screening assessment of any potential new resident prior to admitting new residents to their facility.

SUPPORTS INTENSITY SCALE (SIS)

SIS: Assessments and Telehealth

QUESTION: How should we be completing SIS assessments?

UPDATED ANSWER (4/1/2020): MDHHS has released several policy statements covering telephonic and telehealth (Video/Audio) practices. These can be found on the MSHN Web Site at this link. Posted documents include:

- MDHHS Telepractice Memo dated March 19, 2020
- Revised COVID-19 Encounter Code (This code chart should be used in conjunction with the April 1, 2020 Telepractice Memo)
- MSA Policy 20-09 – General Telemedicine Changes
- MSA Policy 20-12 – COVID 19 Response: Relaxing Face-To-Face (Service Delivery) Requirements

Questions about these MDHHS document should be directed to: MDHHS-ProviderQualificationCode@michigan.gov

UPDATE (3/20/2020): BHDDA recommends suspending in-person SIS-A assessments until May 31, 2020 to minimize non-essential contact due to the COVID-19 pandemic. MDHHS has also released the following policy statement:

- MSA Policy 20-13-Telemedicine Policy Expansion
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html (federal guidance on HIPAA compliance supersedes state guidance-confirmed).

AAIDD guidance on SIS telepractice:

AAIDD is aware that DD/ID state agencies have enacted policies and procedures specific to controlling community spread of COVID-19. This will certainly have an impact on face-to-face SIS interviews.

AAIDD will temporarily waive its best practice recommendation for face-face assessments, and this waiver is applicable only during this national crisis. AAIDD will revert to its original best practice guidelines for conducting in-person SIS interviews once the health emergency protocols are lifted. Skype and Zoom, while not the ideal SIS interview format, can be considered as alternative remote interview options.

AAIDD wishes to protect the widespread dissemination of its intellectual property, and our trainers have developed a Respondent Guide for remote/virtual SIS-A assessments. These can be sent electronically to respondents in lieu of the Interview Profile Form and Rating Key. The effectiveness of remote interview formats for SIS interviews depends on several factors-AAIDD recommends the following strategies to ensure the assessment is facilitated in a manner that is considered reliable and valid. These should be considered, in addition to guidance from your department.

- Use an experienced SIS Interviewer to complete the SIS interview, in addition to one who has a fairly high comfort level with technology.

- Ensure the readiness of the family/respondents for the interview by engaging in some preliminary prep work and communication of the process.
- Ensure transparency of the remote interview process just as you would with the in-person interview. Consider how attestation forms, checklists, required signature forms, other required documents, etc., will be made available to the respondents and returned to the agency.
- Ensure access to and comfort with the technology being used by respondents.
- Ensure the interview can be conducted in a manner that adheres to HIPAA and confidentiality guidelines and requirements. Consider the interviewer's location in addition to the respondents.
- Utilize the attached Respondent Guide for remote/virtual interviews. The guide outlines the SIS sections, domains, number of SIS items in each section, and relevant rating key used for section/domain. This allows respondents to have a visual and follow-along with the interviewer during the assessment.

SUBSTANCE ABUSE PREVENTION AND TREATMENT

STATUS OF TRAININGS

PREVENTION & TREATMENT QUESTION: What is the plan for MDHHS and MSHN trainings?

ANSWER: All MDHHS trainings through April 14 are cancelled or will be rescheduled. Most trainings through May 14 are also cancelled. For a list of trainings, please check regularly here. More cancellations are likely.

The following MSHN trainings are also cancelled and will be rescheduled: *Trauma Informed Yoga Training* (Bay City), March 25-26; *Addressing Substance Use Disorders with Comprehensive CBT* (BAY CITY) April 1; *Acupuncture Detoxification Specialist Training* (LANSING) April 7-9; *Acupuncture Detoxification Specialist Training* (BAY CITY) April 13-15; *Trauma Informed Yoga Training (*Mt. Pleasant) April 22-23; *Addressing Substance Use Disorders with Comprehensive CBT* (MT. PLEASANT) April 24; *Addressing Substance Use Disorders with Comprehensive CBT* (LANSING) April 29.

PREVENTION & TREATMENT QUESTION: What is the plan for the Heroin and Prescription Drug Summit, April 13-16, in Nashville that providers were notified they could attend?

ANSWER: As of this writing, this conference is still taking place. We anticipate it will be cancelled, however, if not by choice, by mandate when Tennessee follows other states that have banned large gatherings. However, even if it is not cancelled, in the context of a national effort to contain the spread of COVID-19 through social distancing, MSHN cannot support our providers attending a large national conference. We are very sorry to lose this wonderful opportunity for our providers, but your safety and the public interest are our priorities.

QUESTION: What is the status of GAIN trainings over the next two months?

ANSWER: All GAIN I-Core training will continue via email and webinar. Those registered for the "In-Person" GAIN I-Core session on March 24th note that the training will now be held via two Zoom webinar sessions.

Details regarding how and when to participate will be sent directly from Jan Maino. All future sessions will be conducted via email and webinar until further notice.

MCBAP CREDENTIALING

QUESTION: Concerns regarding the temporary shutdown of MCBAP's testing mechanism and its impact on service providers during the COVID 19 pandemic, OROSC offers the following guidance:

ANSWER: OROSC has been in communication with MCBAP to determine how many people could be impacted by the temporary halt on testing. It appears that there are approximately 100 individuals with a development plan, currently, although it is likely that some have already left the field. They will receive a 3-month extension for completing their requirements, if they email MCBAP and make the request. For those with a current credential, they should still submit their materials as required for renewal on schedule. Once reviewed and approved, those individuals will be added to the online list. It is unlikely that MCBAP will be able to update that list daily given the remote working arrangements currently in place. As a result, they are requesting that provider agencies and PIHPs use the online list, for verification of current credentials, or a confirmation email from Susan or Jill indicating that the individual's credentials are valid. If someone with a current credential is short the required continuing education credits for their recertification, then they should contact MCBAP regarding possible options for 1) completing the required hours virtually or 2) requesting an extension. Given that all mail is going to the MCBAP office for recertifications and will be picked up weekly, credentialed staff are encouraged to send their materials in early so as not to slow down the review process.

RECOVERY HOMES

UPDATE: Please note the following guidance provided relative to the provision of substance use disorders in recovery homes during the COVID 19 pandemic:

A recovery home is a person's residence and as such, should take the necessary precautions that any other residence with multiple, non-familial occupants would undertake as recommended via the CDC guidelines, the Stay Safe, Stay at Home Executive Order and related COVID 19 guidance for behavioral health services issued to the PIHPs. If there are services being offered within the home, those should be changed to telephonic or video conferences as recommended in the guidance to the extent that they are able. Depending on the level of the recovery residence, there may be a recovery coach in the residence as an employee. That person should take necessary precautions, while still performing their assigned duties. Any case management that is offered to the residents should also take place by phone or video conferencing. If a person within the house does contract the virus, then the health department should be notified.

It's important to note that recovery homes are not licensed treatment programs, but most are licensed as prevention providers. However, recovery homes provide peer recovery support services that are considered essential services as stipulated in the aforementioned COVID 19 guidance document. There are PIHPs that allow, and support outpatient services provided at the recovery home; however, LARA will not approve the provision of outpatient services in the recovery home and recovery homes have been cited for operating a program without a license. If outpatient services are provided in a recovery home, then the relevant parameters in the guidance document would apply.

QUESTION: Given the Executive Order mandating sheltering at home, how does recovery housing staff manage entry and exit from the recovery homes in shifts?

ANSWER: Recovery home staff are considered essential personnel and are therefore allowed to travel between work and home. All CDC and MDHHS guidelines should be adhered to. In addition, here are some concrete steps and precautions offered by MSHN's Medical Director:

- Designate a time to meet with your staff to educate them on COVID-19 and discuss what they may need to do to prepare.
- Maintain social distancing, keeping a 6-foot distance from others.
- If staff report or display any symptoms like fever, coughing, or shortness of breath, do not allow them to work.
- Ask residents who have been out of the home if there has there been any change in their health condition or any exposure to travel or people who traveled in high-risk areas.
- Prominently post reminders for staff and residents to share any changes in health status.
- Prominently post preventive measures about handwashing, disinfecting high touch areas, maintaining distance of 6 feet, cover nose and mouth when sneezing or coughing, avoid touching the face, etc.

TREATMENT PROGRAMS

Block Grant

QUESTION: Will MSHN be evaluating Block Grant eligibility for people impacted by COVID-19 or just doing a case by case basis?

ANSWER: Providers are expected to verify insurance eligibility for each consumer contact. If a consumer loses their insurance, providers should follow the guidelines in MSHN's Substance Use Disorder Treatment – Income and Eligibility & Fees Policy and Procedure found on the website.

REMI Reporting/Documentation

QUESTION: Will the REMI due date for the discharge report will be changing?

ANSWER: The UM Discharge Report providers are required to submit by the 2nd Friday of each month will *not* be required to submit for the month of April 2020.

QUESTION: When submitting an initial or reauthorization request for Medication Assisted Treatment (MAT) services if the client's sessions recently have been conducted via telehealth only due to COVID-19, what is the correct way to document that no toxicology testing has been performed recently?

ANSWER: Providers should check the box indicating no toxicology has been collected in the last 30 days (as seen below) and then document in the "Comments" section of the authorization that it is due to conducting telehealth sessions only in response to COVID-19. The MSHN UM department will process these authorizations as normal.

Residential: Service Hours

QUESTION: Given staffing challenges for providers with the Coronavirus, is there flexibility for residential providers with required hours (core and lifeskills)?

ANSWER: Yes, providers can substitute alternatives for required hours including online resources, virtual groups, individual activities and other strategies to reduce people being in close quarters. Wherever possible, utilize evidence-based activities and document what activities were provided.

Residential: Social Distancing

QUESTION: How do residential providers balance risk strategies like social distancing with best-practices in residential treatment like structured programming, often in group formats, and other relationship and trust-building activities?

ANSWER:

- Consider reducing census limit to create more space to help mitigate risk with social distancing
- Consider creative use of space & smaller groups that allow for the required social distancing
- Consider use of virtual recovery meetings including online NA, AA, Smart recovery groups, etc.
- Consider alternative extra-curricular activities like books, puzzles, radios, cards, etc.
- Use Zoom and other platforms to allow for connection but at a distance.
- Do daily symptom checks of clients and staff.
- If a client becomes symptomatic, isolate on-site if possible, and immediately contact your local public health department

Residential: Transition to Recovery Housing

QUESTION: With the COVID 19 State of Emergency and social distancing mandate, we do not want to move people between residential and recovery housing until their exposure risk has been ruled out. Can we bill recovery housing for these individuals while they remain at our residential site until it is clear for them to move?

ANSWER: If the residential provider has the recovery housing codes attached to their license, they can bill at the recovery housing rate. They can bill for a person who is ready to move into a recovery house but needs to remain at the residential site until the risk from exposure for COVID 19 has passed and people are able to safely relocate to recovery housing.

Residential, Withdrawal Management, Recovery Housing: Limited Census

QUESTION: Is it acceptable if residential/withdrawal management/recovery housing providers limit their census in order to implement recommended social distancing guidelines for residents of the program? (i.e.: A program's typical capacity is 20 but they limit admissions to 12 in order to allow sufficient space between residents in group sessions, dining room, commons areas, etc.).

ANSWER: Yes, it is acceptable to limit census in order to practice recommended risk mitigation strategies as long as providers are not implementing broad holds on all admissions. MSHN encourages all providers to follow the risk mitigation strategies recommended by CDC, MDHHS, and their local health departments.

Out of Network Residential

QUESTION: For residential providers who are located outside of MSHN's geographic area, will MSHN consider opening outpatient and recovery housing service codes so that clients who complete residential treatment can remain on campus and continue to receive services if it is unsafe for them to return home?

ANSWER: If there are extenuating circumstances for particular individuals that would make it unsafe for them to return home upon completion of residential treatment, providers are encouraged to call the MSHN

UM Department at 1-844-405-3095 and we will work with your team to develop appropriate resolutions on a case by case basis. MSHN may approve the use of expanded services codes for specific individuals as needed, if it is determined to be in the person's best interest to preserve their health and safety.

Transportation

QUESTION: How do providers address transportation to get clients home after an episode of care given limited or suspended public transportation options (e.g. bus and train)?

ANSWER: Out-of-region residential providers have expressed concern that consumers might become "stranded" if Greyhound suspends operations. In all cases where transportation becomes an issue, MSHN would encourage providers to work with the consumer to identify alternate methods of travel. MSHN will authorize the purchase of gas cards (T2003) to assist consumers and their support systems with transportation or authorize mileage reimbursement (S0215) to the provider if the consumer can be transported by agency staff. Both transportation codes should already be available to residential providers in REMI and can be selected on an ancillary authorization form. If providers have additional questions about this process, they are welcome to call the UM Department at 1-844-405-3095

SUD: Telehealth

QUESTION: What codes can or should be used for telehealth?

ANSWER: Currently approved telehealth codes that are available will be expanded to permit their being offered through telephone only (in other words, the face-to-face service requirement associated with most telehealth/tele practice/telepsychiatry/telemedicine services will be waived).

Update:

- MDHHS Telepractice Memo dated March 19, 2020COVID-19
- Encounter Code (This code chart should be used in conjunction with the March 19, 2020 Telepractice Memo)

NEW **QUESTION: Should I be billing at normal rates or using the telemedicine services rates?**

ANSWER: Providers should bill using their service rates. The MSHN *reimbursement* rates are the same if done face-to-face or via telemedicine. The rates listed on the database list are the DHHS rates and vary from MSHN rates.

QUESTION: Clarification regarding billing and eligibility for telehealth services with using treatment codes with modifiers for telehealth. If using audio only at this time is that still eligible for treatment codes with a GT modifier in REMI?

ANSWER: Please refer to the following two documents on MSHN's website:

- Encounter Code Chart – COVID-19 F2F Allowance (GT modifier and Place of Service 02 is noted
- MSA Policy 20-13 – COVID Response: Telemedicine Policy Expansion; PIHP/CMHSP Implications

QUESTION: Which services can be billed under telehealth, e.g. Individual Therapy, Group Therapy, Assessments?

UPDATED ANSWER (4/1/2020): MDHHS has released several policy statements covering telephonic and telehealth (Video/Audio) practices. These can be found on the MSHN Web Site at this link. Posted documents include:

- MDHHS Telepractice Memo dated March 19 and April 1, 2020
- Revised COVID-19 Encounter Code (This code chart should be used in conjunction with the April 1, 2020 Telepractice Memo)
- MSA Policy 20-09 – General Telemedicine Changes
- MSA Policy 20-12 – COVID 19 Response: Relaxing Face-To-Face (Service Delivery) Requirements
- MSA Policy 20-13 – COVID 19 Response: Telemedicine Policy Expansion; PIHP/CMHSP Implications, issued March 20, 2020

Questions about these MDHHS document should be directed to: MDHHS-ProviderQualificationCode@michigan.gov

NOTE: Previous guidance provided by MSHN is rescinded effective 03/18/2020.

QUESTION: Can we do assessments over Zoom or how does MSHN want us to proceed with that?

ANSWER: Virtual assessments are allowable under COVID-19 rules currently. Please refer to the list of codes on our website for a complete list of allowable encounters.

QUESTION: Which professionals can bill for telehealth service, e.g. LMSWs, LPCs, LLPCs, Case Managers, Recovery Coaches, etc.?

ANSWER: The professional listed per MDHHS staff qualifications chart for the service being billed may bill for Telepractice services.

QUESTION: Are there specifications regarding what kind of platform is used, e.g. Zoom, Skype, Face-Time, telephonic?

ANSWER: No particular platform is required. Security rules will be relaxed which will permit platforms that don't have the level of security previously required (like Skye, facetime, etc.).

QUESTION: Does MSHN have a list of known HIPAA compliant video software?

ANSWER: Please refer to MSA 20-12 and 20-13 on our website and this FAQ for references to video practice guidelines referencing HIPAA compliance, along with relaxing of HIPAA standards during the COVID_19 pandemic.

HIPAA compliant versus non-compliant video software is dependent on the way the technology is implemented and used. (Zoom, FaceTime, MS Teams, Doxy.me, GoTo Meeting, along with other technologies) are all capable of being HIPAA compliant when used properly and usually require establishing that compliance with the vendor so that they can ensure it on their end. Constraints are typically due to video recording, point to point transmission, and any logging of activities.

MDOC Assessment

QUESTION: Given the current state of government buildings being closed and jail access being limited how should referrals and consent to release be documented?

ANSWER: On the referral form (MDOC Form CFJ 306) the agent would document that they attempted to get a release and couldn't due to social distancing, but that the individual verbally consented. Then the referring agent would send the completed referral form CFJ 306 to MSHN via mdoc@midstatehealthnetwork.org. In the absence of a consent, SAMHSA has issued the following guidance, COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance.

GAIN Assessment

QUESTION: Given moving to telehealth in the current situation, should we continue to use the GAIN?

ANSWER: The GAIN is not required until 10/1/20 so during this crisis, it's recommended that treatment providers use whatever psychosocial assessment they were using before the GAIN that better lends itself to the telehealth process.

Coordination of Benefits

QUESTION: I have a client with primary commercial insurance who is funded secondary through REMI block grant. I have called this individual's primary insurance to inquire about telehealth coverage as our agency has temporarily suspended face-to-face contact. Unfortunately, the client's primary insurance plan does not offer telehealth as an available service whatsoever. I know generally REMI will only pick up secondary what is allowed by the primary plan, but given the current situation I was wondering if I may bill the primary, get a denial for place of service, and still be eligible for REMI to help fund the services as telehealth is approved through MSHN.

ANSWER: Per MSHN's claims procedure, providers should bill the primary insurance for services covered by the identified payer. Since the primary insurance in this case has not expanded telehealth services, please submit the Explanation of Benefits (EOB) form showing the denial and claim to MSHN for payment consideration.

Case management services (H0006) are not generally covered by Medicare or other third-party insurances. Please seek service authorization through MSHN's Utilization Management department and follow standard billing practices.

QUESTION: Will MSHN cover the cost of telehealth and/or co-pays if the third-party payer won't cover?

ANSWER: Providers should seek reimbursement from third party insurances as outlined in MSHN's Claims Procedure. In addition, once providers receive an Explanation of Benefits (EOB) from the primary payor it should accompany the claim to MSHN.

QUESTION: I was wondering if there could be a consideration of adopting the Medicare codes for the next 90 days to help with Covid-19 outbreak??

ANSWER: PIHPs and MDHHS have been working together to finalize Coordination of Benefits for Medicare/Medicaid consumers including the acceptance of G-codes at the State level. The MDHHS guidance has not been finalized. Providers should bill Medicare if coverage is available using the most appropriate code for the service. If the person served **does not** have Medicare or your organization has not completed

the Medicare enrollment process, please bill to MSHN the applicable H-code or other approved codes outlined in your treatment contract.

Case Management

QUESTION: Regarding the H0006 code for case management restrictions for services, are there any restrictions, i.e. are we able to continue to meet with clients via telehealth or phone calls to connect them with resources and other case management functions?

***UPDATED* ANSWER:** H0006 does not require a face-to-face contact to be billed and therefore, reporting requirements have not changed. That is, H0006 will not get reported using POS 02 and GT modifier, even if the service is offered via telehealth, including telephonic methods.

Financial Stabilization/Reimbursement

QUESTION: Will there be a penalty if providers are unable to use all of our grant funds due to disruptions from the Coronavirus, for example, cancelled professional development and programs, reduced needs for program supplies, etc.?

ANSWER: MSHN understands that providers are dealing with diminished capacity to perform many functions including some that are grant-funded. There will be no penalties for low utilization of grant funds. The deadline for use of grant funds are outside of MSHN control, however. The STR grant period ending April 30, 2020, for example, cannot be extended past that deadline to allow a resumption of funding under that grant once the current crisis passes.

QUESTION: Can Fee-for-Service programs be moved to cost reimbursement for a few months during these this financial stabilization for MSHN as well to know what providers may require at these early stages of the issue instead of waiting to see how the finances are impacted by all these decisions.

ANSWER: As an update to previous guidance for Fee-for-Service (FFS) providers, MSHN is implementing an interim step for fund requests. The Cash Advance Request should be completed and emailed to MSHN's Chief Financial Officer Leslie Thomas at leslie.thomas@midstatehealthnetwork.org by April 1, 2020. Download the form here. The form should cover the provider's anticipated loss revenue from March 16 – May 31, 2020. This information will be reviewed by MSHN for reasonableness based on claims utilization for the prior 3-6 months.

Additional documentation such as Income Statements, Statement of Activities, and Bank Statements may be requested if the cash advance request exceeds the reasonableness threshold as defined by MSHN. In such cases, MSHN's CFO will work with the provider's representative until a funding agreement amount can be reached.

Two equal installments will be made on approved requests, one on April 17, 2020 and the other May 15, 2020. These payments are intended to cover operational expenses since there will be a decrease in service delivery. No provider repayment is expected. Additional payments for dates of service after May 31, 2020 may be considered as more information becomes available.

This notice does not apply to Cost Reimbursement or FFS/Cost Reimbursement providers.

Project Assert

QUESTION: Where do Project ASSERT coaches fall in the Executive Order "prohibiting visitors that are not necessary for medical care?"

ANSWER: While EDs now have protocols to screen patients for symptoms (often before they come in the door), we understand that hospitals' emergency rooms may feel unsafe for Project ASSERT coaches. If a provider or a coach wants to suspend operations at this time, MSHN will support that. Many hospitals are also likely to suspend Project ASSERT operations as "non-essential."

We would ask that Project ASSERT coaches work with their ED partners to be "on call" for any patients who present to the ED with an SUD diagnosis or issue. When a patient with a SUD presents at the ED, ED staff could call and make a referral to the Project ASSERT coach who could connect with the patient via phone and then follow up to help support connecting the individual to treatment.

OTP: Methadone Take-Home Dosing

QUESTION: To mitigate Coronavirus risk for our Opioid Treatment Providers (OTPs) and those receiving treatment there, are there any exceptions regarding take-home dosing with methadone?

ANSWER: Federal guidance issued on Thursday indicates no blanket exceptions for take-home dosing will be granted. All take-home dosing arrangements must be individualized and submitted to MDHHS per current practices. However, MSHN recognizes the current crisis is extremely fluid and keeps evolving so MSHN has sought additional guidance from MDHHS regarding flexibility in our OTP practices.

Providers Unwilling to Admit

QUESTION: We have experienced the refusal of services for our clients this past week at a number of treatment facilities (withdrawal management and residential). In light of the recent directives from the State about essential services (BHDDA Communication #20-01), how should we respond when we encounter facilities who are unwilling to admit patients?

ANSWER: All providers of services in residential settings (withdrawal management, residential treatment, recovery residences, etc) should be implementing telephonic phone screenings for individuals seeking admission to services. If an individual has current symptoms of respiratory illness or indicates they have been exposed to an individual with COVID-19, the service provider may refer the individual to their primary care physician and an outpatient SUD treatment provider for telehealth services. If the person seeking services is asymptomatic with no known exposure to COVID-19 and they otherwise meet criteria for the services they are seeking, the provider should schedule an admission. If you become aware of facilities that appear to be implementing broad admission restrictions without implementing the appropriate risk screening protocol, please notify coronavirus@midstatehealthnetwork.org so that MSHN may work with the provider to ensure they understand the expectations of the BHDDA Essential Services Communication. Additionally, you may reach out to the MSHN Utilization Management Department at 1-844-405-3095 if assistance is needed locating a service provider.

PREVENTION PROGRAMS

Financial Stabilization/Reimbursement

QUESTION: We pay a stipend to Community Peer Recovery staff who we contract with to do support groups. Since we need to cancel these groups, can we still provide these staff with the stipends they would have received?

> **ANSWER:** MSHN can pay the stipend for the cancelled activities. If the stipends are being submitted as invoices, please note "cancelled activity" on the invoice.

QUESTION: NOFA funding that ends March 31st for community forums we had scheduled for the last two weeks of March. As we had to postpone these, is it possible to extend our funding so we can do in the fall?

> **ANSWER:** To the extent allowable, MSHN will extend approved funding to allow activities to occur as previously planned.

QUESTION: The closing of schools, universities, etc. will preclude some cost-reimbursed activities that were in annual plans. Can we continue billing for these staffing costs even though they will not be able to show the progress expected on plan direct service hours?

> **ANSWER**: Cost reimbursement programs should be billed based on costs incurred. When evaluating utilization and other progress indicators, MSHN will consider decreases related to Coronavirus.

QUESTION: How can prevention providers get required direct hours given schools are cancelled, meetings are cancelled, agencies are closed, and most events are cancelled?

> **ANSWER**: Given all the current closures, MSHN understands that your direct hours will be lower than planned. Please keep track of how many direct service hours you were unable to complete during this time and we will make adjustments as needed.
>
> During the Provider Meeting (via teleconference) on Thursday, March 19th, ideas for non-face-to-face activities will be discussed and brainstormed. Some ideas include:
>
> - Pull data together for your counties (Michigan Automated Prescription Drugs Data -here, Michigan Liquor Control Violations here, FDA tobacco compliance data -here; and the Michigan SUD data repository - here.
> - Begin planning for your MSHN FY21 Annual Plan
> - Spend time looking at your program evaluations to see what is working and what needs to be changed
> - Download your MPDS data and review

Vendor Education/Synar

QUESTION: We would like to know if you wish us to continue Vendor Education at this time, or if we should suspend these activities to minimize contact?

> **ANSWER**: In response to COVID-19 concerns, MSHN in consultation with MDHHS is offering the following changes to the Synar timeline:

- May 15 – June 30 Vendor Education and Non-Synar Checks
- July 1 – July 19 Quiet Period
- July 20 – August 14 Formal Synar Survey (4 weeks)
- August 21 Synar results spreadsheet due and original compliance check forms sent to MSHN
- August 28 Synar results spreadsheet and original compliance check forms due to MSHN

QUESTION: How should prevention providers handle Synar activities and what timelines should be used? And how should federal law changes in Tobacco 21 (re: the legal age to smoke rising to 21) be handled?

ANSWER: Per OROSC, the following timeline will be used to implement Synar activities this fiscal year. There will be a need for flexibility depending on new information and guidance stemming from COVID-19.

- May 15 – June 30 Vendor Education and Non-Synar Checks
- July 1 – July 19 Quiet Period
- July 20 – August 14 Formal Synar Survey (4 weeks)
- August 21 Synar results spreadsheet due and original compliance check forms sent to MSHN
- August 28 Synar results spreadsheet and original compliance check forms due to MSHN

SAMSHA has not made a decision if Synar protocol for this fiscal year will include 18-20-year-old persons. Given that, MDHHS has directed us to move forward with current protocol of using youth ages 16 and 17, as well as including ENDS products to be purchased.

Lastly, on March 3, 2020, the Senate Regulatory Reform Committee received testimony for vaping product legislation SB 781, SB 782, SB 783, SB 784, SB 785 and SB 786. The intent of the legislation is to raise the legal age for smoking to correspond with federal law changes (Tobacco 21) and create a state regulatory structure for vaping products (license ENDS retailers). The bills were taken off the agenda for March 10. MDHHS will keep us posted if further action is taken to revise the Youth Tobacco Act to age 21.