MSHN
Mid-State Health Network

Coronavirus Disease 2019 (COVID-19)
Frequently Ask Questions
As of June 10, 2021

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.

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

The table of contents is 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. Updated answers are marked with **UPDATED** to highlight any changes to previous guidance.

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GENERAL GUIDANCE

Appendix K Expiration

QUESTION: How does the expiration of Appendix K fit into the mix with all the executive orders and changes from MDHHS? Some aspects are cut and dry like the temporary exceeding service limitations and the end of the extension of the timeliness of provider training requirements but other areas not so much. The example below is just one area:

> **PIHP/CMH may contact beneficiaries or their authorized representatives telephonically, using telehealth or other available technology as appropriate. Providers must ensure the privacy of the beneficiary and the security of any information shared via telephonic, telehealth and video technology, in accordance with HIPAA. For required in-person visits for case management/supports coordination and provider assessment/monitoring activities, MDHHS will expand telehealth options: Telephonic, telehealth and video technology commonly available on smart phones are acceptable options for program functions that require in-person communication and the beneficiary or legal representative consents to the method.**
>
> **ANSWER:** MSA Bulletin 20-30 provides guidance on COVID response: relaxing the face to face requirement, which includes the allowance to use telephonic or simultaneous audio and video technology. This includes the following programs: Children's Waiver Program, Children's Special Health Care Services, Flint Waiver, Habilitation Supports Program, Healthy Michigan Plan, Michigan's Section 1115 Behavioral Health Waiver Program, MIChild, MI Choice Waiver, MI Health Link, PACE, MOMS, Waiver for Children with Serious Emotional Disturbances. Given the circumstances of the pandemic, this MSA policy is intended to be time-limited, and MDHHS will notify providers of its termination and/or replacement with new telehealth allowable services.

COVID VACCINE

QUESTION: Where can providers find out information regarding the COVID-19 vaccine?

> **ANSWER:** Michigan.gov coronavirus page has the most updated information regarding the COVID-19 Vaccine and can be located at: https://www.michigan.gov/coronavirus/vaccine. This site also includes a link to a dashboard that includes vaccines shipped, administered, enrolled providers etc. https://www.michigan.gov/coronavirus/vaccine/dashboard.

COVID Positive Cases Reporting

QUESTION: We are hearing from other PIHP/CMHs that a contact person at the PIHP/CMH has been identified as having authority from the Health Department to be our contact if we have a positive or suspected COVID case. Does MSHN have a contact person with this authority?

> **ANSWER:** No, MSHN does not serve as an alternate authorized reporting authority for any of the 21 counties that comprise our region. The response strategies of each county health department differ based on the population density and rates of disease transmission within each county. SUD Providers should report

positive/suspected cases of COVID-19 directly to the health department for the county in which the SUD provider program is located.

COVID Testing

QUESTION: Can Block Grant cover the cost of a COVID-19 test if the client has symptoms. We typically bill that to the client's Medicaid and their Medicaid covers the testing cost.

ANSWER: COVID-19 Testing can be done at NO cost. Click here for a list of locations across the state currently providing testing at no cost.

NEW FACE to FACE Provisions

QUESTION: Has MSHN mandated that all the CMHs in their region start doing in office psychiatric appointments (with the resident coming in and doctor still being on zoom)?

ANSWER: No, MSHN has not issued a mandate but continues to follow MDHHS guidance about face-to-face services. On April 26, 2021, MDHHS issued a clarification to their March 3, 2021 memo regarding the expectations for the provision of face-to-face home and community-based services and supports, regarding the use of telemedicine. According to the Centers for Medicare and Medicaid Services (CMS), telemedicine is defined as "…activities involving two-way, real time interactive communication between the patient and the physician or practitioner at [a] distant site. Prior to the COVID 19 pandemic, many services were provided in this manner, such as psychiatric care, and the communication was not intended to disrupt that previous practice or other standing practices. The memo indicates that there have been numerous complaints about CMHSP denying or not offering in-person home and community-based services and supports. Despite having a very strong telemedicine framework, it does not mean that face-to-face services can be suspended. Face to face, home and community-based services must be provided unless they cannot be provided safely to minimize the risk of transmission of COVID-19, or if the family specifically requests telehealth services; either instance should be well documented. Individuals can refuse face-to -face services which should also be documented. If the CMHSP denies the face-to-face service provision when requested and offers only a virtual option, detailed documentation must be kept to explain the health or safety rationale for this decision. Use of telemedicine shall be offered when clinically appropriate and upon parent, youth, or individual request as one modality of service delivery. Face-to-face services continue to be a best practice model for individuals accessing behavioral health services. The MIOSHA Emergency Rules does not limit the provision of face-to-face behavioral health, home and community-based services. The MIOSHA rules address workplace safety and standards that employers must put in place because of COVID-19.

Behavioral Health – Treatment Episode Data Set (BH-TEDS)

QUESTION: MDHHS has received several questions on how to answer specific BH-TEDS fields in the light of COVID-19.

ANSWER: The short answer is that BH-TEDS collected during this time should reflect what is truly happening in accordance with the BH-TEDS Coding Instructions.

NOTE: BH-TEDS Updates are NOT required for changes in status due to COVID-19 related circumstances. That is, BH-TEDS updates are still only required annually, generally at time of the annual review.

For individuals who start services, end services, or are due for their annual update during the COVID-19 Epidemic, consider the following when completing the BH-TEDS record:

- Employment Status –
  - Individual who typically works in a competitive, integrated environment continues receiving pay while working at home or not working due to the Stay at Home Order should report Full-time or Part-time Competitive, Integrated, depending on the number of hours being paid.
  - Individual who is laid off due to COVID-19 circumstances should be reported as Unemployed
  - Individuals who lose their job (other than lay-off) or stop participating in a Not in the Labor Force Activities (i.e. workshop) because of the Stay at Home Order should report Unemployed.
- Work/Task Hours – Report actual hours the individual performed the work/task in the last 2 weeks. If an individual is not actively looking for employment because their position is being held for them to return to after the Stay Home Order is lifted, it is fine to report 0 hours. Again, report what has occurred.
- Earnings Per Hour should reflect what they have earned in the last 2 weeks divided by the number work/task hours.
- Minimum Wage should reflect:
  - 1-Yes if they're being paid at least minimum wage
  - 2-No if they're earning less than minimum wage
  - 3-Not Working if they are not working (including laid off)
- Annual Income remains the annual income utilized in determining Ability to Pay (ATP)
- School attendance should also be answered as it occurs during this time of the Governor's shutdown of school buildings. Since school includes "School includes, but is not limited to, any one or combination of home-schooling, online education, alternative school, vocational school, or regular school (public, private, charter, traditional, military, magnet, independent, parochial, etc.", it is likely that most children's school attendance will be one or a combination of these types during this time.

Verbal Consent

QUESTION: Is it MSHN's expectation that staff need to follow up to secure a written signature, or is documentation of the verbal consent to treat adequate?

ANSWER: It is the expectation of MHSN that staff need to follow up to obtain written consent after verbal consent has been obtained and that all attempts to obtain written consent should be documented, along with verbal consent, in the recipients record. The Policy Bulletin MSA 20-30 that was referenced allows for verbal or written consent for use of virtual methods as alternatives to in-person communication, but it does not alter the requirement that all attempts must be made to follow up verbal consent with written consent for treatment as identified in the memo dated March 20, 2020 and titled "Accept Verbal Consent for Services."

The memo dated March 20. 2020 (Accept Verbal Consent for Services) states that per the 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 their 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.

The Policy Bulletin MSA 20-30 (COVID-Response: Relaxing Face-to-Face Requirements) that was issued on November 4, 202 expands the flexibility related to face-to-face requirements of in-person communications. This bulletin provides updates in order to clarify the virtual communication options regarding permitted technologies, Health Insurance Portability and Accountability Act (HIPAA) compliance, and screening considerations for virtual visits to ensure consistence with federal and state guidance issue subsequent to Bulletin MSA 20-12. It goes on to state that during this time, providers may use telephonic or simultaneous audio and video technology for program functions that require in-person communication so long as the beneficiary or legal representative provides verbal or written consent to these "virtual" methods. The memo also states that the use of alternative methods of in-person communication must be documented as a comment on the provider claim and in the beneficiary record, as appropriate. The conditions may also warrant documenting the rationale for alternative methods and the beneficiary's preference or consent. Providers should notify the beneficiaries of the privacy and security risks of any information shared using these methods. Providers should enable all available encryption and privacy modes of the application and make every effort to ensure the privacy of the beneficiary and the security of information shared.

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.

Verbal Consent: SUD & Communicable Disease

UPDATED QUESTION: Have you been made aware of any loosening on the standard of verbal consent to release Substance use or communicable disease info? We were asked to release this information from a recipient, to another CMH (SUD & Communicable Disease info) without a written consent (only verbal). Wondering if you know of anything that would permit us to do this?

ANSWER: SUD Information: The rules governing release of information for Substance Use Patients are under 42 C.F.R Part 2. During the COVID-19 crisis, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidance titled "COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance." In the guidance it states that the prohibitions on use and disclosure of patient identifying information under 42 C.F.R. Part 2 would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists. Under 42 U.S.C. §290dd-2(b)(2)(A) and 42 C.F.R. §2.51, patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained. Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed. We note that Part 2 requires programs to document certain information in their records after a disclosure is made pursuant to the medical emergency exception. We emphasize that, under the medical emergency exception, providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.

Communicable Disease Information: The Office of Recipient Rights (ORR) and Behavioral Health and Developmental Disabilities Administration (BHDDA) has temporarily suspended 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. However, there are additional rules that govern the release of information on some communicable disease, such as HIV (MCL 333.5131), that need to be adhered to.

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: Yes, the memo dated April 8th, 2020 was rescinded on June 15th, 2020. Per the BHDDA essential services guidance #20-01 issued on March 25,2020, "All behavioral health services are essential to sustain and protect life and therefore must continue to be provided under the Governor's Stay Home Stay Safe Order. Behavioral health services shall continue to be provided in homes, residential or clinical settings if

such services cannot reasonably be performed telephonically or through other virtual methods and are necessary to sustain and protect life. 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.

If an authorized service is not being provided due to consumer choice, then this needs to be clearly documented within the consumer chart. The provider should periodically check in with the individual to ensure that the temporary suspension in services is still the choice of the consumer. In the situation of consumer choice, an adverse benefit determination is not required. If services are suspended, reduced, or terminated based on the judgement of the provider that the service is not necessary to sustain and protect life, then an adverse benefit determination shall be provided to the client. Person-centered plans (PCP) should be brought or kept up to date as a result of the recission of the terms delineated in the April 8th, 2020 memo, thereby ensuring that needed services and supports are appropriately authorized to continue. The removal of the Stay Home, Stay Safe order also affected the extension of the PCP services and assessments for different levels of need, but since telemedicine is tied to the state of emergency, everything afforded in MSA 20-13 remains in effect. This includes determining whether the service should be face to face or not. The worker needs to determine whether an assessment and PCP activity can be completed via telepractice or needs to be face to face with the necessary precautions in place.

QUESTION: Related to the above guidance; Failure to engage is the consumers choice but we have not heard that from them for confirmation. That said without any response by the consumer we believe we could close the case after full implementation of our engagement protocol, and the termination of service would require an ABD because that determination would be based interpretation by the clinician. Is this in fact correct?

ANSWER: There is no current guidance regarding closing client cases due to non-engagement in services during this time of state of emergency. A provider agency can follow their internal processes to determine if the client is not engaging in services and if determined to not be actively engaging, can choose to close services which would necessitate issuing an adverse benefit determination notice. However, during this time of a pandemic, many regulations are becoming flexible and changing to ensure that our vulnerable population is being served. Some of our vulnerable populations may not be actively engaging at this time for a variety of reasons which may not include a choice to no longer receive services. The mental health system should exercise caution when choosing to close cases during this time and exercise flexibility with our current standards for closing cases due to non-engagement.

QUESTION: Regarding a current appeal, if the Adverse Benefit Determination notice indicating termination of services, based on no longer meeting medical necessity criteria, was mailed to the individual on March 24, 2020 (with an effective date of April 4, 2020), could it be required that the services continue based on information found in the April 8th, 2020 MDHHS memo entitled; "Plan of Service and Due Process Concerns"? The specific language from the memo in question is the following: "To ensure that individuals receive necessary services, MDHHS expects that services currently authorized in the Person-Centered Plan (PCP) will continue during the COVID-19 emergency even if the plan and authorizations are set to expire. In addition, MDHHS expects that during the COVID-19 emergency, assessments for a different level of need should be suspended and no adverse actions initiated."

ANSWER: If the service that was terminated did not meet medical necessity criteria, the individual can be provided an ABD that includes appeal rights. If the service is being terminated for a reason other than lack of medical necessity, continuation of the services in compliance with the MDHHS memo is appropriate.

Updated Answer (03/30/2021): The MDHHS memo "Plan of Service and Due Process Concerns" has been rescinded. The individual plan of service should be developed/amended based on medical necessity criteria.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "Due Process" whenever their Medicaid benefits are denied, reduced, or terminated. Due Process requires that Enrollees receive prior written notice of the adverse action. An adverse benefit determination must be issued for the following actions:

1. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
2. Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
3. Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
4. Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1*).

QUESTION: We are serving someone who will be receiving Arnold Center services. This is a new annual IPOS (not an extension or addendum) in which they're putting in interventions saying they're necessary without authorizing the service due to COVID-19. I'm thinking that because this is a new IPOS and we don't know when Arnold Center will reopen there are two options: you either authorize the service and put in the interventions to maintain those with a caveat that states that due to COVID the service is delayed and will be reinstituted once the center opens and send a delayed ABD, or you don't authorize the service and you don't put it in the interventions section until you have an IPOS addendum when services resume once they reopen.

Which one of these options would be recommended as standard practice by MSHN?

ANSWER: It is acceptable to provide a future agreed upon date for the start of services identified within the plan of service. The start date must be mutually agreed upon by the client/guardian and CMHSP. However, if the service is identified as medically necessary, then the plan of service should identify rational as to why the service provision is being delayed and also how the current need will be met until such time the identified service is available.

An Adverse Benefit Determination would not be needed based on the following definition that is part of the ABD: Failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning and as authorized by the PIHP. 42 CFR 438.400(b)(4). An ABD would only be needed if the mutually agreed upon start date of service is exceeded by 14 days.

Question: In reference to above, for the instances where the service(s) has/have been requested for inclusion by the consumer/guardian in the IPOS/PC, but due to the pandemic the provider is not currently providing services, what direction should be taken?

ANSWER: If there is no agreed upon start of service, but it is identified as medically necessary and the consumer/guardian requests it be included in the IPOS, then it can be included with the provision that the service date cannot be identified at this time as the service provider is not currently providing services due to the pandemic. In this situation an adverse benefit determination would need to be issued stating why there is no start date of a medically necessary service that is included in the IPOS and why the service cannot be provided at the current time. In addition, since it is a medically necessary service, the IPOS needs to identify other services/supports that can be offered to meet the need until such time the identified service can be provided.

QUESTION: We have received a question about what to do as Skill Building programs are opening back up. They plan on opening Skill Building with limited numbers of consumers to come to the program and they plan on using CDC guidelines for social distancing, masking, etc. The issue is there are consumers who want to return to the programs and there will not be enough space. There are a couple of phases the programs are being opened to in April: Phase # 1: Independent, without the need for physical assistance for care of ADLs; Phase # 2: Minimal hands on for ADLs; Current Phase: Receiving Skill Building remotely. There will not be any community outings. Here are the questions we have:

Question:

1) **If someone asks to return to Skill Building, when does the request become official and have to be acted on?**

   ANSWER: The request becomes official and has to be acted on when the consumer's case holder receives the request. According to the Appeal and Grievance Resolution Processes Technical Requirement, the following timeframes need to be met, and if not met, then will require an adverse benefit determination notice be sent to the client:

   - A standard Service Authorization decision, including providing notice about the decision, within 14 calendar days from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).
   - An expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. 42 CFR 438.210(d)(2).
   - Start the provision of services within 14 calendar days of the start date agreed upon during the person-centered planning (PCP) meeting and as authorized by the PIHP. 42 CFR 438.400(b)(4).

2) **If someone asks to return but they do not meet the criteria for return specifically for one of the phases, what should the process be?**

   ANSWER: An adverse benefit determination notice would need to be issued providing the reason as to why the service was reduced, suspended (delayed) or terminated.

3) **Does an ABD have to be sent out if they request the service, but the program is not in a phase that would include their situation? Example: In Phase # 1 (Independent) and a consumer who needs care in eating, toileting, and can't wear a mask requests to attend.**

   ANSWER: Yes, an adverse benefit determination notice is required. In this situation, the reason would either be a denial or a delay depending upon the consumer's situation.

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.

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.

UPDATE: Additional interim guidance released by American Heart Association on Card Extensions during COVID-19 outbreaks which supersedes guidance issued on March 13, 2020.

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.

UPDATED Training: Timeliness Requirements

QUESTION: What is MSHNs position on timeliness for meeting training requirements during this time for all staff as outlined in the MSHN regional training grid?

ANSWER: MSHN is following the guidance as outlined in MSA 20-58 which extends the timelines of provider training requirements for Direct Support Professionals during the pandemic. However, direct Support Professional (DSP) providers must still be age 18 or older, trained in universal precautions, be competent in completing required tasks, and be able to effectively communicate with the beneficiary. All required training must be completed as soon as possible, but not to exceed the end date of Appendix K (currently no later than 6 months after the expiration of the public health emergency). See MSA Bulletin 20-58 above for specific provisions for Behavior Technicians and Qualified Behavioral Health Professionals.

MSHN is authorizing a similar extension to all staff types as identified in the MSHN regional training grid, including the requirement to be competent in completing required tasks. Providers should attempt to ensure all required trainings are completed as soon as possible after the expiration of the public health emergency but no later than 6 months after. Providers must have documentation to support delays in meeting training timeliness requirements (e.g., no available trainings, staffing shortages, etc.).

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

MDHHS Epidemic Orders and MIOSHA Emergency Rules lay out restriction and related safety considerations. See links below.

MDHHS Epidemic Orders
MIOSHA Emergency Rules

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 is 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 is easier to maintain 6 feet distance from others.

UPDATE:
MDHHS released guidance on 11/4/2020 - MSA 20-30: COVID-Response: Relaxing Face-to-Face Requirement (Update). Considerations should be given for when a service should be provided via tele-practice in lieu of face to face to protect all individuals. This should be documented in the record as a comment on the provider claim and in the beneficiary record, as appropriate. The conditions may also warrant documenting the rationale for alternative methods and the beneficiary's preference or consent.

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: I have read the MSA bulletins but am confused about Medicaid continuing to pay for telehealth services. My original understanding was that Medicaid would continue to pay for telehealth services for 30 days after the end of the state of emergency. Please advise if Medicaid and block grant funded outpatient treatment will continue to be reimbursed for telehealth? Is there a known end date Medicaid and block grant funded clients will not be able to utilize telehealth anymore? Will it be ongoing as a payable service?

ANSWER: Telehealth currently remains a payable service. MSA 20-36 ties the telemedicine expansion COVID Response policy to the Governor's state of emergency declaration. Once the state of emergency is discontinued, the COVID response policies were to terminate 30 days after, but MSA 20-36 further clarifies that the temporary COVID-19 Response policy MSA 20-13 COVID Response: Telemedicine Policy Expansion; Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) Implications, will remain in effect until further notice and is not subject to the termination of the Governor's Declaration of a State of Emergency Executive Order. More information will be forthcoming about the potential for ongoing use of telehealth beyond MSA 20-36.

UPDATE: MSA Bulletin 20-30 discusses the flexibility related to face-to-face requirements of in-person communications, including use of telephonic or simultaneous audio and video technology and given the circumstances of the pandemic, this policy is intended to be time-limited, and MDHHS will notify providers of its termination.

QUESTION: Can telehealth services be provided to a beneficiary who happens to be temporarily out of state?

ANSWER (6/29/2020): Yes, this is a billable Medicaid activity/expense based on the fact that the beneficiary is a Medicaid (Michigan) beneficiary, the prescriber is licensed in the State of Michigan and providing services to an established patient under current Medicaid policy. The fact that the beneficiary was in a state in which the prescriber was not licensed is immaterial due to the bona fide patient/prescriber relationship and the other factors stated here. (Confirmed by BHDDA 06/29/20)

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 (11/17/2020)**: 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
- MSA Policy 20-30-COVID-Response: Relaxing Face-to-Face Requirement (Update); expands flexibilities related to face-to-face requirements, issued November 4, 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.

QUESTION: We are looking at doing Zoom Health group meetings with 6-8 people. I did not see a 90853 covid 19 teleheath code available, only a covid 19 face to face group code (which is doing group face to face still)? Is there a code for us to use to start doing groups via Zoom health?

ANSWER: See Encounter Code Chart - 90853 is on the COVID-19 chart highlighted in yellow which means the service is usually not available as telehealth but can now be provided as such because of the pandemic.

Telehealth and Telephonic Practices: Overlapping Services

QUESTION: Is onsite CLS and a telehealth outpatient therapy session allowable if it overlaps?

ANSWER: Please see the 4.27.20 Telemedicine Case Management Monitoring Clarification Memo on MSHN's website. The argument can be made for therapy and CLS to occur simultaneously as long as both staff are engaged.

QUESTION: As a follow up to the above question, are the services interchangeable as long as the professional and specialty provider report the activity as outlined?

ANSWER: Under normal circumstances a therapy and CLS session would not occur at the same time however since the question is related to telehealth there would not be a physical transfer of responsibility to the therapist. If the CLS staff person is engaged and providing a CLS activity to ensure the therapy session occurs, the overlap is permissible and defensible.

QUESTION: The delivery times of some services may overlap with the delivery times of other services, such as Clubhouse services overlapping with a 15-minute CLS service. Will this and other similar situations be allowed overlaps *during this pandemic*?

ANSWER: Both Clubhouse and CLS services may be provided via audio only based on the relaxed telehealth guidance. The response is the same as initially provided in terms of occurring simultaneously. In this case, if both workers are engaged in the activities the services are permissible.

Telehealth and Telephonic Practices: Performance Indicators

QUESTION: Are telephonic services considered a valid reportable service for the purposes of the performance indicators during the time period in which temporary telehealth (MSA 20-30) policy is in place?

ANSWER: Telephonic services are considered a valid and reportable service and should be used in the reporting of performance indicators during the time frame that is allowable under the new telehealth policies.

The Michigan Department of Health and Human Services (MDHHS), in the Medicaid Bulletin MSA 20-09, updated program coverage for telemedicine services including the definition, consent requirements, privacy and security requirements, allowable originating sites, distance site procedures and billing and reimbursement. After receiving additional guidance from the Centers for Medicare and Medicaid Services (CMS), MDHHS released further policy guidance, Medicaid Policy Bulletin MSA 20-12, regarding allowable face-to-face encounters with beneficiaries during the COVID-19 crisis. This new guidance allowed for the use of nearly all communication methods for interacting with individuals as long as the individual (and guardian when applicable) is able to utilize the method and has consented to the use. This also allowed for the use of telephone contacts.

The Behavioral Health and Developmental Disabilities Administration (BHDDA) also established a COVID-19 Encounter Code Chart. This chart will be in effect until further notice. The chart clearly delineates which codes can be used with the methods described in the face-to-face guidance as well as those that do not apply.

Related policies include: MSA Policy 20-30–– Relaxing Face-to-Face Requirements

Telehealth and Telephonic Practices: Rounding Rules

QUESTION: Is there any chance that the rounding rules on the "90832 Individual Therapy" coding during COVID can be relaxed as has been done with other codes?

> **ANSWER** (PER MDHHS): We have reviewed your request to allow 90832 (Psychotherapy W/Pt 30 Minutes) to be billed/encountered when the duration of the service is less than 16 minutes. This raises concerns about quality of care provided to consumers. A contact of 15 minutes or less is appropriate for a case management (T1017) or supports coordination (T1016) check-in, but we do not consider a service of this short of a duration to be conducive to psychotherapy.

Telephonic: Billing and Third Party

UPDATE 1.15.21 **GENERAL GUIDANCE:** Per MDHHS guidance provided 11.6.2020, Medicaid funds may be used when Medicare does not cover a service for substantive reasons (e.g., service not covered). This decision overturns the guidance issued in August 2020 in which services not meeting primary insurers rules should be charged to General Fund.

MDHHS has an additional update on the 11/6/2020 email sent regarding phone-only evaluation and management services provided to dual eligible beneficiaries.

MDHHS advises that providers who are associated with CMHSPs/PIHPs are permitted (if the modality of audio/visual has been sufficiently explored and is not possible), for dual enrolled beneficiaries, to note in the beneficiary's record that a service was provided via audio only (thus meeting Medicaid rules) and subsequently submit that encounter to Medicaid without having to submit it to Medicare and receive a denial. Furthermore, providers associated with CMHSPs/PIHPs are advised that this guidance only applies to those services that are allowable via Medicare via audio/visual and where the only difference is that Medicaid is allowing the modality of audio only to be used (thus all other requirements are being met).

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. Please see updated general guidance.

QUESTION: So with there being no way to get a rejection from Medicare our stance would be keeping the Medicare policy on hand for audit purposes and not sending those claims, but keeping track of those encounters and reasoning for why they were not sent.

> **ANSWER**: If the provider is not able to obtain a Medicare rejection, MSHN suggest documenting the unique reason a primary insurance EOB cannot be obtained. MSHN recommends to reporting the encounter to as

MDHHS has relaxed its telehealth standards and audio only is permissible for Medicaid/HMP payment. Please see updated general guidance.

Suspending all Medicaid Closures, including suspension of deductibles

CORRECTION MSA Policy Bulletin Update: 20-19

As a result of the federal emergency health declaration for COVID-19, the Michigan Department of Health and Human Services is suspending program coverage closures for all Medicaid programs beginning **March 18, 2020** and will be in effect until such time the federal emergency health declaration has expired. Medicaid coverage will only be closed if the individual moves out of state, requests that their benefits close, or they become deceased.

The temporary suspension of closure applies to Medicaid, MI Child, Healthy Michigan Plan and individuals who have active coverage through a met deductible. Individuals who meet their deductible during the declared health emergency period will remain open until the end of the health emergency.

This policy is being implemented in order to ensure that all Medicaid beneficiaries are able to receive needed medical services during the time of COVID-19 national health emergency. Proposed Medicaid policies may be accessed here on the MDHHS website.

QUESTION: Can we assume that CHAMPS will reflect these extensions of coverage from March, or do we need to be handling this on our end somehow?

ANSWER: If eligibility has not already been ended on the last day of March; the individual will be eligible through the federal declaration of emergency. If the coverage ended effective 3/31/2020 BEFORE 3/18/2020, coverage will stay ended. The federal requirement to stop all eligibility from ending went in place for actions taken on or after 3/18/2020.

If coverage ended before 3/18/2020 then coverage is showing ending 3/31/2020. After 3/18/2020, there is no case actions to end Medicaid eligibility. Bridges updates have been made and I believe a daily script is running to catch any that fall through the cracks.

Suspending all Medicaid Closures: Spenddowns

QUESTION: How exactly Medicaid eligibility will be handled during the crisis? Will CHAMPS reflect this?

ANSWER: If Medicaid eligible in March, will be eligible through this crisis. If Spenddown was met in March, it will be considered met each month going forward during crisis.

QUESTION: For consumers who did not meet their deductible in March, can medical expense still be sent to DHHS to process or is it too late?

ANSWER: Only if they meet their spend down will they remain open. So, in this case, they would not be eligible for March, but for April. Also, if they don't meet their spenddown in the 3-month period they won't be dropped and will remain an open as a spenddown.

QUESTION: For the consumers who did not meet their deductible in March, will a April deductible report still be required to be sent to DHHS in order for them to have continued Medicaid coverage for the rest of the month after the deductible was met?

ANSWER: Yes, so they can be remain open.

Suspending all Medicaid Closures: Incarcerated

QUESTION: Will there be an exception at this time for the incarcerated to reinstate their Medicaid upon release?

ANSWER: Have them apply on MiBridges to get their cases opened. Healthy Michigan Plan requires almost no verification and if they need a verification check list it will be sent to them but there are links on MiBridges to help them get the verification they need. The IRS website for example.

Provider Licensing

Provider Sanctions:

QUESTION: Will sanctions be applied to providers who are unable to meet contractual expectations during the COVID-19 State of Emergency?

ANSWER: During the COVID-19 social isolation MSHN contracted providers having difficulty meeting contractual expectations, including reporting requirements, are encouraged to contact MSHN. To the extent we are able, MSHN, recognizing provider unique circumstances, will work with the provider to address/resolve.

Visitors

QUESTION: Can we allow residents to have visitors?

ANSWER: The MDHHS Emergency Order under MCL 333.2253-Requirements for residential care facilities indicates that facilities must prohibit visitors from entering their facilities. For purposes of this order, visitation includes indoor and outdoor visitation unless otherwise specified. Facilities may only permit visitation when the facility meets all of the following criteria:

(1) The facility has had no new COVID-19 cases originate in the facility, including those involving residents or staff ("facility-onset cases"), within the prior 14 days and is not currently conducting outbreak testing. Admission of a resident who is known to be COVID-19-positive at the time of admission does not constitute a facility-onset case;

(2) The facility is in a county where the current Risk Level on the MI Safe Start Map is Low, A, B, C, or D with the exception of outdoor visits which are permitted in counties where the current Risk Level is E;

(3) The local health department has not prohibited visitation at the facility.

Facilities allowing visitation consistent with this order shall follow all visitation rules as set forth in the MDHHS Emergency Order, including those elements spelled out in 2(c)(1)-(19). All elements of the order shall be followed.

AFC HOMES: Visitor Restrictions

QUESTION: Are AFC homes still had to remain stay at home or were the visitor restrictions lifted? Also can vocational and or ABA providers phase back into services now?

UPDATE **ANSWER:** **Emergency Order-Requirements for residential care facilities** addresses entrance into all residential care facilities, residential care facilities, congregate care facilities, and juvenile just facilities, including safety precautions for those who are allowed to enter. In light of the noted rise in COVID cases since the fall, MDHHS has issued the Emergency Order-Gatherings and Face Mask Order that requires the use of face masks as well as limitations and safeguards being placed on certain settings and gathering sizes. It is not recommended that service phase-ins be occurring at this time.

DAY PROGRAMS

QUESTION: Where do ID/DD Day Programs fall in the Executive Order? Our program bills H2015TT, when can we open up on a smaller scale or start doing virtual groups?

ANSWER: Please ensure that you are consulting with your Community Mental Health plan for reopening as there may be elements and considerations of local reopening that this answer may not have adequately addressed. Services that involve more individuals in one enclosed area, such as a building or space in a building should be reviewed closely for the implementation of safety protocols including social distancing measures recommended by the Centers for Disease Control, including remaining at least six feet from people and wearing a face covering over the nose and mouth, such as a homemade mask, scarf, bandana, or handkerchief, unless the individual is unable to medically tolerate a face covering. Per MDHHS Emergency Order-Gatherings and Face Mask Order, gatherings of specified sizes for indoor and outdoor gatherings are specified, along with limitations. Please also reference MSA 20-12 and MSA 20-30 which clarify options relating to the relaxation of face-to-face service requirements in favor of telephonic or virtual contact allowances. MSA 20-12 also notes:

"Providers should use their judgement regarding the risk to beneficiaries and employees, and the relative need for in-person communication with beneficiaries that have complex care needs. Communication with beneficiaries to assess these factors prior to any in-person contacts is required. At a minimum, providers should ask the following questions before in-person activities:

1. Do you or anyone in your household have symptoms of Coronavirus including fever, cough, sore throat, or shortness of breath?
2. Have you or anyone in your household traveled in the last 14 days? If so, where?
3. Have you or anyone in your household been in close contact with others who have symptoms, are being assessed or monitored for Coronavirus, or who have travelled in the last 14 days?
4. Have you or anyone in your household been at a large gathering of 50 people or more in the last 14 days?
5. Are you uncomfortable having a provider enter your home during the Coronavirus outbreak?

If the beneficiary or employee answer "yes" to any of the above questions, a postponement of in-person activities is strongly recommended and a referral to a healthcare provider or Local Health Department

should be facilitated. The individual conducting outreach to the beneficiary shall assist in securing transportation services to the healthcare provider or Local Health Department if needed."

DIRECT CARE STAFF: TRAINING

QUESTION: Is there any guidance for direct care staff who are in need of initial or refresher trainings during the pandemic where face-to-face options may be limited.

UPDATED **ANSWER:** The MSHN regional training glossary also outlines the training objectives for all required trainings and therefore, Providers and/or CMHSPs may identify or develop trainings that meet those requirements. ImprovingMIPractices.org has several online training modules at no cost.

CONGREGATE SERVICES

QUESTION: The guidance appears to be a continuation of seeking alternative service arraignments (telehealth, face to face and one on one....) needing to be the utilized or other service support options provided (CLS face to face and one on one) "in lieu of " of congregate services for skill building, CLS, and Clubhouses….. Does this continue to be the guidance of MSHN and MDHHS? Are there any exceptions to this guidance?

ANSWER: The current MDHHS epidemic order, effective March 22 through April 19, indicates the limits on attendance at non-residential gatherings for indoors is up to 25 persons and outdoors up to 300 persons. These limits must include wearing a face mask at all times unless eating or drinking while seated in a designated area. Eating or drinking can only be done in groups of no more than six people and they must be six feet apart.

a. Limitations to gatherings do not apply to:
    1. Gatherings for the purpose of medical treatment, including mental health and substance use disorder support services
    2. Residential care facilities, which are subject to the March 17, 2021, epidemic order entitled "Requirements for Residential Facilities," or any replacement of that order.

The MDHHS memo; "Expectation of the Provision of Face-to-Face Services" dated March 3, 2021 also indicates the following:

"Despite having a very strong telemedicine framework, it does not mean that face-to-face services can be summarily suspended. In accordance with the July 8, 2020, Essential Behavioral Health Services in the COVID-19 Context: Updated Guidance Communication document #20-11 "The clinical rationale for the modality used, including face-to-face, or the use of telephonic or virtual services shall be made with input from individual(s) served and must be documented on an individualized basis. Such rationale shall be reviewed and updated regularly as the individual's needs and the public health crisis evolves. This communication can be found at the below link: https://www.michigan.gov/documents/mdhhs/BH_Communication_Essential_Virtual_and_F2F_Services_COVID-19_Guidance_20-11_695961_7.pdf. Face to face services must be provided unless they cannot be provided safely, or if the family specifically requests telehealth services; either instance should be well documented. Individuals can refuse face-to-face services and that should also be documented. If the CMHSP denies face to face service provision when requested, strong documentation would be needed. The Person

Centered or Family Driven Youth Guided Individual Plan of Service should reflect a clinical determination of how services will be provided for each individual. CMHSPs must not tell beneficiaries that they can only receive home and community-based services through telemedicine, this type of decision must be done on an individual level as part of the planning process. Individuals and families must be presented with choices about the way in which services can be provided."

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?

UPDATED **Answer:**
The March 19, 2021-Gatherings and Face Mask Order updates guidance and concludes that control of the epidemic is necessary to protect the public health and that it is necessary to restrict gatherings and establish procedures to be followed during the epidemic to ensure the continuation of essential public health services and enforcement of health laws.

May adult day programs for people with behavioral health needs (such as drop-in centers, clubhouses, or adult skill-building programs) continue in-person operations under this Order?
Programs are permitted to remain open to provide physical and behavioral health services for residents, including those related to mental health, substance use, and developmental disability (such as counseling, group programs, peer coaching, and vocational, physical, or occupational therapy). All programs should follow the guidance provided by MDHHS specific to their operations and relevant MIOSHA guidance.

The March 19, 2021 order indicates that face masks are still required at all indoor and outdoor gatherings of any kind. The following are general capacity limitations at gatherings and apply to clubhouses (PSR), drop-in centers, site-based day programming (CLS, PC, Skill building), and similar services would be supported by MDHHS:

a. Indoor gatherings:
    1. Are prohibited at residential venues, except where no more than 15 persons from no more than 3 households are gathered. Such gatherings should be held consistent with guidance issued by the Department of Health and Human Services for such gatherings; and
    2. Are prohibited at non-residential venues, except where no more than 25 persons are gathered.
b. Outdoor gatherings are permitted only as follows:
    1. At residential venues, where 50 or fewer persons are gathered.
    2. At non-residential venues, where 300 or fewer persons are gathered.
c. Limitations to gatherings in a. and b. do not apply to:
    1. Gatherings for the purpose of medical treatment, including mental health and substance use disorder support services.
    2. Residential care facilities, which are subject to the March 17, 2021, epidemic order entitled "Requirements for Residential Facilities," or any replacement of that order.

The March 3, 2021 MDHHS memo entitled; "Expectation of the Provision of Face-to-Face Services" also notes that; "The clinical rationale for the modality used, including face-to-face, or the use of telephonic or virtual services shall be made with input from individual(s) served and must be documented on an individualized basis. Such rationale shall be reviewed and updated regularly as the individual's needs and the public health crisis evolves." This communication can be found at the below link:
https://www.michigan.gov/documents/mdhhs/BH_Communication_Essential_Virtual_and_F2F_Services_COVID-19_Guidance_20-11_695961_7.pdf

Face to face services must be provided unless they cannot be provided safely, or if the family specifically requests telehealth services; either instance should be well documented. Individuals can refuse face-to-face services and that should also be documented. If the CMHSP denies face to face service provision when requested strong documentation would be needed.

CAFAS/PECFAS TRAINING CERTIFICATIONS

QUESTION: We have some staff whose CAFAS/PECFAS training certification are about to expire. According to the MSHN Training Grid the CAFAS/PECFAS training is required by MDHHS within 90 days of the date of hire and then every two years thereafter. Because the CAFAS/PECFAS training is a face-to-face training what is MSHN's position on expired CAFAS/PECFAS certification due to COVID restrictions?

ANSWER: MSHN will relax the refresher timeliness standards during this time if training resources are limited and/or staff are focused on providing essential direct services and capacity is limited to complete annual refresher trainings – simply note this in personnel files/training records as due to COVID-19. MSHN's expectation is that training requirements are completed as soon as reasonably possible.

CASELOAD SIZE

QUESTION: Does MDHHS have the ability to waive (or increase) caseload sizes for positions that are presently restricted in order to open up the opportunity for additional case assignments in light of projected workforce shortages or for redeployment to deliver services in areas where the redeployed staff are properly credentialed/capable? If so, will MDHHS please consider?

ANSWER: During this COVID crisis, all the home-based service frequency of contact requirements outlined in the Medicaid Provider Manual would still need to be met. Clinicians should continue to meet these requirements via telehealth (see MSA Bulletin 20-30) as appropriate. At this time, all previous allowances as allowed by the State of Emergency Order 2020-04 fully expired on 5/30/2020.

APPLIED BEHAVIOR ANALYSIS (ABA)

ABA: Appeals, Fair Hearing and Second Opinion

QUESTION: I am working on an appeal in which the appellant wants a second opinion ABA eval. The individual had been receiving ABA services, but these services were terminated after an annual ABA evaluation found that the individual no longer meets medical necessity criteria.

This was our ABA Coordinator's reply to our request for a re-evaluation: "At this time, we are not completing face to face re-evaluations until the State of Emergency has been lifted. One of our staff psychologists would need to complete the second opinion face to face."

Do you know how we are to handle this in terms of the 30-day appeal deadline and possible 14-day extension? If the State of Emergency is not lifted prior to the end of the potential 44-day deadline, should the appeal be kept open? Or would it need to be closed? If so, would a Fair Hearing be available to the individual?

ANSWER: The Medical Services Administration Bulletin, MSA 20-13, issued on March 20, 2020 does allow for an assessment for Autism to be provided via telehealth methods up to 30 days following the end of the state of emergency has ended. This includes HCPCS/CPT codes 90785, 90791 and 90792. Note that MSA Bulletin 20-30 provides an update to clarify virtual communication options but does not change the guidance in MSA bulletin 20-13. Therefore, the provider, for the purpose of providing a second opinion, can use the telehealth process for the evaluation unless there are evaluation components that must be completed face to face. For any service that has been previously authorized and is then terminated, even based on medical necessity, an Adverse Benefit Determination (ABD) is required to be provided to the beneficiary. The ABD must provide information on the appeal process, including the right to a Medicaid Fair Hearing. The appeal process is outlined in Attachment P.6.3.1.1 (Grievance and Appeal Technical Requirement) that is part of the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Program FY20 Contract.

At this time, there are no exceptions to the timelines for completion of the appeal process. If the evaluation for the second opinion cannot be completed within the appeal timeframe, or if the beneficiary does not agree with the outcome of the second opinion, then the beneficiary will have the right to file for a Medicaid Fair Hearing.

ABA: Assessment

QUESTION: ABA providers are asking about the ABA bi-annual/annual assessment and whether they can be postponed. Many of the providers are doing this via telehealth but in some cases this cannot be done. Many of these assessments will be late and out of compliance. Has there been any update on the ability to extend when these are provided?

UPDATED **ANSWER:** There is no further guidance specific to the requirement of the completion of bi-annual or annual assessments at this time. If clinically required, BHDDA Communication 20-07 indicates "All providers should use their judgment regarding the risk of exposing COVID-19 to individuals in service, their family members, staff, providers and others, and the relative need for in-person contact with beneficiaries that have complex behavioral health care needs, and risks if such in-person contact was shifted to an electronic telehealth delivery modality…to the extent possible, in-person ABA services should adhere to social distancing rules, and all people involved should be aware of the importance of wearing a face mask and the importance of invoking other alternatives (e.g., schedule changes) if either provider, beneficiary, or their family develop COVID-19 symptoms. MDHHS received approved guidance on the 1135 Waiver. This included the following guidance: "If prior authorization processes are outlined in Michigan's state plan for particular benefits, CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services approved to be provided on or after March 1, 2020, to continue to be provided without a requirement for a new or renewed prior authorization, through the termination of the public health emergency, including any extensions (up to the last day of the emergency period under section 1135(e) of the Act), for beneficiaries with a permanent residence in the geographic area of the public health emergency declared by the Secretary..

ABA: Annual Evaluations/Re-Evaluations

We have a few clients who are inactive (not receiving treatment at this time as they have opted out of in-home). They have missed too much treatment to inform the VB-MAPP authentically. Can you advise us on how to best handle this? Will we be able to extend the due dates due to the nature of the situation (COVID)?

ANSWER: For annual re-assessments, do not worry if those are late. The 1135 waiver has been fully approved by CMS as of April 6, 2020. There will be up to 12 months to get those reassessments done after the state of emergency has been lifted. This is 12 months from the end of the authorization period if it ends during the state of emergency. The 12 months starts the date the state of emergency is lifted.

**This applies to the below questions as well related to evaluations.*

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: Providers are wondering if the ABA bi-annual/annual assessment can be postponed if necessary?

ANSWER: BHDDA has waived the prior authorization of telehealth for ABA in response to the virus and is pursuing approval to waive current evaluation requirements and other barriers identified for the Medicaid ABA Benefit Program through the 1135 authority. It is expected to include allowing the extension of re-evaluations for up to one year and presumptive eligibility by waiving the evaluation requirements in order to start or maintain services and verify or evaluate formally up to 12 months later. Also, the Medical Services Administration Bulletin, MSA 20-13, issued on March 20, 2020, does allow for an assessment for Autism to be provided via telehealth methods. Given the circumstances of the pandemic, this policy is intended to be time-limited, and MDHHS will notify providers of its termination.

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:** CMS provided approval of the 1135 waiver on April 6, 2020 with an approval update on 9/21/2020. 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:

- MSA Policy 20-30 COVID Response-Relaxing Face-to-Face Requirements (Update)
- 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 practice for ABA appeals is to request a second evaluation be completed by a different provider when the initial evaluation is appealed due to not having anyone with the expertise to determine if the first evaluation was adequate. There are currently not any providers who are conducting evaluations face-to-face evaluations unless it is an emergency situation, which this is not. The plan was to reach out to the guardian and inform them that they are on a waiting list and a second evaluation will be done as soon as possible. Can you advise on what other steps I should take since we cannot complete this appeal within the 30 days?

ANSWER: MDHHS is currently pursuing all available options to address this through federally approved channels. These channels include flexibilities that enable states to waive prior authorization requirements which includes the extension of deadlines for appeals and state fair hearing requests. Michigan has received approval to waive certain requirements in Medicaid and CHIP under Section 1135 authority on April 6, 2020 with an approval update on 9/21/2020. Additionally, it may not be clinically practical, but there is the option of conducting an evaluation virtually/remotely in lieu of a face to face evaluation, as telephonic and/or telehealth methods are allowable during the COVID-19 crisis.

UPDATED ANSWER:
Unless preempted elsewhere in another guiding document, the March 19, 2021-Gatherings and Face Mask Order updates guidance and concludes that control of the epidemic is necessary to protect the public health and that it is necessary to restrict gatherings and establish procedures to be followed during the epidemic to ensure the continuation of essential public health services and enforcement of health laws. Programs are permitted to remain open to provide physical and behavioral health services for residents, including those related to mental health, substance use, and developmental disability (such as counseling, group programs, peer coaching, and vocational, physical, or occupational therapy). All programs should follow the guidance provided by MDHHS specific to their operations and relevant MIOSHA guidance.

The March 19, 2021 order indicates that face masks are still required at all indoor and outdoor gatherings of any kind. The following are general capacity limitations at gatherings and apply to clubhouses (PSR), drop-in centers, site-based day programming (CLS, PC, Skill building), and similar services would be supported by MDHHS:

a. Indoor gatherings:
    1. Are prohibited at residential venues, except where no more than 15 persons from no more than 3 households are gathered. Such gatherings should be held consistent with guidance issued by the Department of Health and Human Services for such gatherings; and
    2. Are prohibited at non-residential venues, except where no more than 25 persons are gathered.
b. Outdoor gatherings are permitted only as follows:
    1. At residential venues, where 50 or fewer persons are gathered.
    2. At non-residential venues, where 300 or fewer persons are gathered.
c. Limitations to gatherings in a. and b. do not apply to:
    1. Gatherings for the purpose of medical treatment, including mental health and substance use disorder support services
    2. Residential care facilities, which are subject to the March 17, 2021, epidemic order entitled "Requirements for Residential Facilities," or any replacement of that order.

The March 3, 2021 MDHHS memo entitled; "Expectation of the Provision of Face-to-Face Services" also notes that; "The clinical rationale for the modality used, including face-to-face, or the use of telephonic or virtual services shall be made with input from individual(s) served and must be documented on an individualized basis. Such rationale shall be reviewed and updated regularly as the individual's needs and the public health crisis evolves." This communication can be found at the below link: https://www.michigan.gov/documents/mdhhs/BH_Communication_Essential_Virtual_and_F2F_Services_COVID-19_Guidance_20-11_695961_7.pdf
Face to face services must be provided unless they cannot be provided safely, or if the family specifically requests telehealth services; either instance should be well documented. Individuals can refuse face-to-face services and that should also be documented. If the CMHSP denies face to face service provision when requested strong documentation would be needed.

ABA: Direct Care Wage

QUESTION: The MSHN guidance that was sent with the $2 DCW increase stated that it was for "in home" services. Then further codes including ABA codes were added to the list of eligible codes to pass it through to. A question was asked this morning, if an ABA provider provided those codes in a center-based facility and not in the home would they be able to receive the $2 an hour for those codes?

ANSWER: The memo issued by MDHHS on May 18, 2020 on Premium Pay Increase for Direct Care Workers specifically states:

UPDATE – **Effective 7.1.2020 MDHHS issued a communication removing place of service restrictions.**

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.

QUESTION: **How does it work if the consumer is on inactivity during a 6-month assessment? Do we need to take them off inactivity?**

ANSWER: If the family has chosen to be inactive during the crisis, the case should remain inactive and ABA services should continue their ABA enrollment eligibility. The state received approval of an 1135 waiver on April 6, 2020 with an approval update on 9/21/2020, which allows for presumptive eligibility to maintain services with the flexibility of being able to verify formally using what is currently in policy at a later time when the crisis is over.

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.

ABA: School Year Services

UPDATE School Year Services Subject: On October 30, 2020, BHDDA issued Communication 20-13: Guidance for Coordination of Behavioral Health Medicaid Waiver Services and Educational Distance Learning in the COVID-19 Context. Due to the coronavirus disease COVID-19 pandemic, many schools are now offering distance learning options. There are questions about whether the Prepaid Inpatient Health Plans (PIHP)/Community Mental Health Services Program (CMHSP) system can or should be providing behavioral health services during virtual school hours. Medicaid-funded behavioral health services that do not interfere with a child's education can and should be provided during virtual school hours if medically necessary and not duplicative of any in-home behavioral supports or services being provided by the school during this time. Such services should be coordinated with school personnel accordingly. In general, effective collaboration and coordination between community agencies while confronting the historical challenges and impact of COVID-19 are critical. Person-centered practice and family-driven/youth-guided planning is essential in responding to the pandemic and providing the most effective care. This guidance is intended to outline the requirements set forth by federal and state rules as well as considerations of coordination between publicly supported community behavioral health services and public education school services.

QUESTION: I have recently received some phone calls from parents/guardians whose children received ABA services. The parents/guardians feel that with school not being held as normal and the children going through a virtual learning environment, that the summer break ABA services be offered at this time.
We are not considering this as summer break and we are authorizing the amount and duration of ABA services as if they are in school for the full day. When the parent requests for increased ABA hours what is the best way to handle it; including what language to put in the ABD?

ANSWER: At this point, it is still considered the school year. If there are any requests for an increase in services that are denied, the CMSHP still needs to provide an adverse benefit determination letter to the family. MSHN recommends reviewing the wording related to 18.10, "BHT Service Level" as represented in the Michigan Medicaid Provider Manual.

ABA: Service Delivery, Closures, lay-off, etc.

QUESTION: Why have some ABA providers closed their facilities to consumer Services?

ANSWER: ABA services are deemed essential along with other Behavioral Health services. MDHHS relaxed its standards related to the face-to-face requirement for ABA services. Providers should maintain service delivery based on the ability to render ABA services via telehealth.

QUESTION: Is there a different payment arrangement as there would be limited overhead cost due to closers?

ANSWER: Fee-for-Service arrangements should be honored for face-to-face and telehealth services. MSHN recommends providers receive the same rate regardless of service delivery method.

QUESTION: What If they laid off their staff or continued to pay them even when the facility was closed?

ANSWER: ABA providers to the degree possible should render telehealth services to maintain continuity of care for the person served. Providers have the authority to manage their staff in a manner consistent with internal policies, procedures, and/or business practice.

QUESTION: What If they continued to provide services but laid off some staff due to families not wanting to risk the exposure during the pandemic?

ANSWER: Refer to the items above. Telehealth services available to eliminate the risk of exposure to COVID-19 for staff and person served.

QUESTION: What if face-to-face intervention is needed for a severe case?

ANSWER: Provider may request enhanced reimbursement to assist with Personal Protection Equipment (PPE) and other considerations for in person service delivery.

ABA: Telehealth

QUESTION: As the phase in process for services begins, are you still reviewing face to face services for ABA (or any other service) versus telehealth at this time?

ANSWER: MDHHS has issued Medicaid Bulletins 20-12, COVID-19 Response: Relaxing Face-to-Race Requirement, MSA Bulleting 20-13, COVID-19 Response: Telemedicine Policy Expansion, and for further clarification, MSA Bulletin 20-30 COVID-Response: Relaxing Face-to-Face Requirement (Update). Given the recent MDHHS Emergency Epidemic Order, Gatherings and Face Mask Order, in response to the rapid rise in COVID-19 positive cases in Michigan, it is inadvisable to be considering face-to-face services. All bulletins and orders noted should be reviewed.

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:** 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)
- MSA Policy 20-30-COVID-Response: Relaxing Face-to-Face Requirement (Update); expands flexibilities related to face-to-face requirements, issued November 4, 2020

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: Has there been any clarification as to whether ABA services, notably Parent Training, can continue to occur, if the consumer's 6 Month ABA Assessment is overdue and is unable to be completed via telehealth?

ANSWER: Please review the preceding answer and related content. Through the 1135 waiver approval, re-evaluations will be extended for up to one year. Through the 1135 waiver, which would allow the determination of a "presumptive eligibility," waiving the evaluation/re-evaluation requirements in order to start or maintain services with the flexibility of being able to verify/evaluate formally using what is currently in policy at a later time (potentially up to 12 months) when the crisis is over. Family Behavior Treatment Guidance (97156, 97157) can be provided via telehealth. Per the approved 1135 waiver (4/6/2020): If prior authorization processes are outlined in Michigan's state plan for particular benefits, CMS is using the flexibilities afforded under section 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services approved to be provided on or after March 1, 2020, to continue to be provided without a requirement for a new or renewed prior authorization, through the termination of the public health emergency, including any extensions (up to the last day of the emergency period under

section 1135(e) of the Act), for beneficiaries with a permanent residence in the geographic area of the public health emergency declared by the Secretary.

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
- MSA Policy 20-13-Telemedicine Policy Expansion
- MSA Policy 20-30 COVID Response: Relaxing Face=to-Face Requirement (Update)
- 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: 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: Telehealth & Adverse Determination

QUESTION: If they do not qualify for face to face, were offered tele-health & additional parent training and declined – do we send an adverse determination?

ANSWER: First confirm that the family wishes to be inactive, and not receiving services, during the state of emergency. If the family has chosen to be inactive during this time, the case should remain inactive and ABA services should continue their ABA enrollment eligibility. The state is seeking approval of an 1135 waiver, which will allow for presumptive eligibility to maintain services with the flexibility of being able to verify formally using what is currently in policy at a later time when the crisis is over.

QUESTION: MSHN has recommended that CMH's review face to face ABA cases and assess risk of Covid-19 vs risk of missing ABA services. The clinical manager and clinical supervisor have decided that 8 cases should not receive face to face services right now. We can offer tele services, but the providers and families have requested to continue F2F and we are denying their request. The service is not being denied; however, the modality (face-to-face vs. tele services) is. Should we send action notices to the family that ABA services are being suspended if they refuse to do tele services?

ANSWER: Per the BHDDA essential services guidance #20-01 issued on March 25,2020, "All behavioral health services are essential to sustain and protect life and therefore must continue to be provided. Behavioral health services shall continue to be provided in homes, residential or clinical settings if such services cannot reasonably be performed telephonically or through other virtual methods and are necessary to sustain and protect life. 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. If the clinician has determined that this service can be reasonably provided telephonically or through other virtual methods, and is not required to be performed

face-to-face in the home to sustain and protect life, then it is acceptable to do so during the time that option to provide services via telemedicine remains available as tied to the Governor's state of emergency and state of disaster declarations. If the service is being provided within the amount, scope and duration as indicated in the plan of service, then a change in delivery method during this time of crisis, would not necessitate an adverse benefit determination. However, even with the provider following the guidelines provided, the consumer/family may still file an appeal if they wish to and the formal Grievance and Appeal process as outlined in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries must be followed.

QUESTION: **If an Adverse Benefit Determination (ABD) is not required to be provided, then an appeal is not an option….that is my understanding. Do you mean file a grievance?**

The following is clarification for the previous response to this question.

ANSWER: The MDHHS/PIIHP Specialty Services and Support Contract (Section 6.3.1) states that individuals enrolled in Medicaid, Healthy Michigan and the Flint 1115 Waiver must be informed of their right to if dissatisfaction is expressed at any point during the rendering of state plan services. PIHPs must offer a local appeal process to resolve the dispute. The local process must be completed or deemed exhausted due to notice or timing requirements not being met before the MDHHS administrative hearing process is requested. The PIHP shall follow fair hearing guidelines and protocols issued by the MDHHS.

Contract Attachment P.6.3.1.1 defines the appeal process to include an appeal which is used to dispute an adverse benefit determination and grievance which is utilized to express dissatisfaction about PIHP/CMHSP service issues, other than an adverse benefit determination.

So the appeal process is always available to beneficiaries and depending on the situation, the specific process followed would either be a formal appeal (for an adverse benefit determination) or a grievance (for issues other than an adverse benefit determination).

QUESTION: If they do not qualify for face to face and were offered tele-health and accepted – however hours are not the same as face to face – do we send an adverse determination?

UPDATED **ANSWER:**
Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "Due Process" whenever their Medicaid benefits are denied, reduced, or terminated. Due Process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision measured from the date the complaint is first made. Therefore, if services are suspended, reduced, or terminated based (regardless of face-to-face or telehealth) on the judgement of the provider that the service is not medically necessary, then an adverse benefit determination must be provided to the client.

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.

IDEA/CMHSP SERVICE COORDINATION

QUESTION: Related School (IDEA)/CMH Services Coordination Questions

1. **Do the flexibilities in place right now allow for CLS staff to be working with the consumer at the same time they are attending school via Zoom?**
2. **MDHHS is not allowing ABA during the typical school day still, correct? What if parents are electing virtual school and the hours are different than a traditional school day? Does it still revert to what hours the child would be attending school?**
3. **With many schools offering online/virtual school starting this fall, will there be any restrictions for ABA working in the home and/or coming to centers for what would have been school-time of day? If a student has behavioral issues related to school work online, is that something ABA could do concurrently with school to try to help overcome that barrier?**
4. **Is a "learn at your own pace" ok for ABA to do the service any time, or should it still be what would normally be considered after the normal school hours?**

ANSWER: Per the Medical Services Administration (MSA) Bulletin 15-59, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit indicates that coverage of autism services and supports for children under 21 years of age, "…may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child." As a result of the current pandemic, the "typical school day" has become more fluid as many schools have moved to more virtual platforms (similar to families that choose to home-school their children). However, the same careful coordination of both community mental health and public education resources should be done to maximize the outcomes and to ensure that ABA is not being used to replace educational supports.

If ABA interventions are needed for the student to access the social, behavioral, or academic curriculums then the school staff and IEP planning team should evaluate the level and determine those needs and services. Still, schools are responsible for providing special education, supplementary aids and services; and allowing for appropriate accommodations to enable a child to make expected progress and enable the child to have the chance to meet challenging objectives. Furthermore, the Community Mental Health Services Program (CMHSP) should be able to verify that the prescribed ABA services do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency.

UPDATE:
Please see the 10/30/2020 BHDDA Communication 20-13; "Guidance for Coordination of Behavioral Health Medicaid Waiver Services and Educational Distance Learning in the COVID-19 Context. Due to the coronavirus disease COVID-19 pandemic, many schools are now offering distance learning options. There are questions about whether the Prepaid Inpatient Health Plans (PIHP)/Community Mental Health Services Program (CMHSP) system can or should be providing behavioral health services during virtual school hours. Medicaid-funded behavioral health services that do not interfere with a child's education can and should be provided during virtual school hours if medically necessary and not duplicative of any in-home behavioral supports or services being provided by the school during this time. Such services should be coordinated with

school personnel accordingly. In general, effective collaboration and coordination between community agencies while confronting the historical challenges and impact of COVID-19 are critical. Person-centered practice and family-driven/youth-guided planning is essential in responding to the pandemic and providing the most effective care. This guidance is intended to outline the requirements set forth by federal and state rules as well as considerations of coordination between publicly supported community behavioral health services and public education school services.

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.

UPDATED **ANSWER (FROM MDHHS):** Please review the Appendix K and 1135 documents for details on the conditions of the approvals. MDHHS has pursued and achieved 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 has received approval as of April 6, 2020 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.

QUESTION: There is a sentence in the memo (dated 4/3/2020) that states, "All time spent on planning and documentation required for the service provided is to be included in the total direct time for the service that is reported to the state." This is reading to us, that the state is allowing BCBAs some time to prep for family training sessions via telehealth as part of the 97156 code. Is this something BABHA is allowing during this time?

ANSWER: No, a new MDHHS memo, dated 4/7/2020, clarifies the rules, entitled; Clarification of Rounding Rules for Behavioral Health Services During the COVID-19 Crisis." It states the following, and no longer includes planning and documentation time: "Under this expanded policy, a service may be billed for at least 1 unit if **all** of the following criteria are met:

1. The service is provided through telemedicine; and
2. The amount of direct service time (i.e., time spent interacting with a consumer over telephone or telehealth platform) is at least 1 minute.

For clarification, this temporary policy reduces the minimum threshold for the first unit of 15-minute services provided via telemedicine. Service times will otherwise continue to use standard rounding rules and unit counting. Therefore, under these expanded rules, a service that is billable or reportable using a 15-minute HCPCS code with a total duration of 1-29 minutes will count as 1 unit, and services with a total duration of 30-44 minutes will count as 2 units, etc. Likewise, a service reportable using a 15-minute CPT

code with a total duration of 1-22 minutes will count as 1 unit, and services with a total duration of 23-37 minutes will count as 2 units, etc."

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 emergency epidemic orders, a note that references current COVID-19 restrictions as a result of Governor Whitmer's executive order or MDHHS emergency epidemic 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 located here. Additional information regarding face to face requirements include MSA Bulletin 20-30 COVID-Response: Relaxing Face-to-Face Requirement (Update) and Emergency Epidemic Order: Gatherings and Face Mask Order.

HCBS: Heightened Scrutiny

QUESTION: MSHN CMHs have begun identifying concerns about the ongoing Heightened Scrutiny (HS) process due to COVID issues in the residential settings. This has created extreme stress on the residential system's resources and a request has been made to reduce HS activity so these staff can focus time and energy primarily on supporting beneficiaries.

ANSWER: The majority of MSHN CMHSPs have completed their HS review process without a request for additional time. There is awareness that parts of the MSHN region are struggling with COVID and prior communications have resulted in MSU acknowledging that the affected providers need additional time.

Once providers have communicated through the process noted below, the plan is for MSU to reach out to them at a future date to confirm whether their situation has improved and that they are prepared to move forward.

The process for providers to request for additional time for HS review due to COVID concerns:

1) Reach out to the CMH HS lead and let them know reviews need to be paused based upon COVID issues.
2) The CMH HS leads will then communicate that to MSU. MSU will be agreeable to the request and will circle back to the lead/setting to see if they are ready to move forward at an agreed upon point in time.
3) CMH HS leads should also communicate the request and response from MSU to their designated PIHP HCBS Coordinator.

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: Feedback from MDHHS includes the Emergency Epidemic Order: Gatherings and Face Mask Order. 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: Feedback from MDHHS includes the Emergency Epidemic Order: Gatherings and Face Mask Order. 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.

HABILITATION SUPPORTS WAIVER

QUESTION: What are the flexibilities allowed for the HSW program standard requirement of at least one habilitative waiver service monthly? Will there be expected recoupments for not meeting this requirement?

ANSWER: The CMS approved Appendix K: Emergency Preparedness and Response and COVID-19 Addendum, allows certain flexibilities for the Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), and Waiver for Children with Serious Emotional Disturbances (SEDW). One flexibility is to "temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications." Within this section of the Appendix K, the following clarification is found: "There will be no penalties for delayed contacts. For individuals who are unable to receive the services on the person-centered service plan because of the social distancing recommendations, MDHHS will allow services to be furnished on a less than monthly basis in lieu of requiring the provision of at least one waiver service monthly". This applies to HSW, CWP, and SEDW. If an individual is not receiving a waiver service per program standard requirements, clear documentation of the reason related to COVID-19 should be noted in the individual's chart. Please also note that the Michigan PIHP/CMHSP COVID-19 Encounter Code Chart (revised 9/4/2020) addresses the expansion of the availability of services allowable via telehealth and which may be appropriate in meeting the individual's PCP service amount, scope, and duration needs.

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.

OUTINGS AND OVERNIGHT CAMPS

QUESTION: When outings resume, if our staff are still in masks if it is warm out, outings are not going to be what they used to be. Expectations will have to be lowered. With the heat and with many breaks and air conditioning, still felt overheated. Please make sure this is taken into consideration!

UPDATED **ANSWER:** Note that as cold weather is now present, more people will spend more time indoors and created a greatly increased risk of transmitting and/or acquiring COVID-19. Per MDHHS Emergency Epidemic Order, Gatherings and Face Mask Order and Requirements for Residential Care Facilities Updated guidance should be closely followed, including communal dining and all internal and external group activities for long term care facilities. "Long-term care facility" means a nursing home, home for the aged, adult foster care facility, or assisted living facility. "Adult foster care facility" has the same meaning as provided by section 3(4) of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.703(4). Long-term care facilities should take all necessary precautions to ensure the adequate disinfecting and cleaning of facilities, in accordance with relevant guidance from the Centers for Disease Control and Prevention ("CDC").

QUESTION: A) Are CMHs permitted to begin using and billing for overnight and day camps for this summer? B) Are any of those codes included in the enhanced compensation?

ANSWER: A) UPDATED **ANSWER:** Note that as cold weather is now present, more people will spend more time indoors and created a greatly increased risk of transmitting and/or acquiring COVID-19. Per MDHHS Emergency Epidemic Order, Gatherings and Face Mask Order and Requirements for Residential Care Facilities Updated guidance should be closely followed, subject to guidance by the Department of Licensing and Regulatory Affairs. Please also see the LARA document; "Guidelines for Camp Operations During COVID-19." B) No, enhanced compensation has only been approved through June 2020.

PASARR REQUIREMENTS RELATED TO REGIONAL HUBS

QUESTION: With the new guidance related to Regional HUBS (MSA Bulletin 20-27) , It states "timely" PASARR screening will not be necessary for admissions. So does this mean a screen is still needed after admission as a function of "appropriate verifications subsequent to admission" or not at all?

ANSWER: A PASARR 3877 is not necessary for admission to the HUB. If the person is returning to the same nursing facility upon being discharged from the HUB that is consider a interfacility transfer and a 3877 and 3878 is not needed. If the person is being discharged to a new nursing facility, then a 3877 and if appropriate the 3878 is needed and if necessary, a Level II may need to be completed.

PERSON CENTERED PLANNING

QUESTION: Can Person Centered Planning Meetings (PCPs) held via Zoom count to meet the requirement of an annual PCP, or would CMHSP staff be required to circle around and hold the PCP meeting face-to-face once we are able?

ANSWER: Yes, Person Centered Planning Meetings (PCPs) held via Zoom count toward the requirement of an annual PCP. The April 8, 2020 Memo, "Plan of Service and Due Process Concerns" that extended services even if the plan and authorizations were set to expire, has been rescinded as of June 15, 2020. However, telemedicine service options continue until such time the policies are rescinded. Additionally, per the March 3, 2021 memo; "Expectation of the Provision of Face-to-Face Services; "The clinical rationale for the modality used, including face-to-face, or the use of telephonic or virtual services shall be made with input from individual(s) served and must be documented on an individualized basis. Such rationale shall be reviewed and updated regularly as the individual's needs and the public health crisis evolves."

Also, the March 19, 2021 Gatherings and Face Mask Order indicates that work should be completed remotely unless it is strictly necessary for an employee to be in person to complete their job duties (See **MDHHS's Guidance for Employers (Nov. 6, 2020)** and **MIOSHA's Emergency Rules (Oct. 14, 2020).** Behavioral health Services and activities specified in an individual plan of service (IPOS) for persons with disabilities are considered medical treatment under this Order and are not restricted by this Order's gathering limits. This includes in-person services provided in the home, in communities, and at day centers.

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

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 (11/17/2020)**: 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
- MSA Policy 20-30 – COVID 19 Response: Relaxing Face-to-Face Requirement (Update)

Added (3/30/2021):

- Coronavirus - March 19 - Gatherings and Face Mask Order (michigan.gov)
- Coronavirus - FAQs for the March 19, 2021 Gatherings and Face Mask Order (michigan.gov)

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

(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:

UPDATE: AAIDD has completed a study reviewing the effect of using virtual methods for SIS administration instead of face-to-face. AAIDD found that organizations can have confidence in SIS-A assessments that have been conducted using virtual methods.

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.

QUESTION: Is there a standard for returning to face to face that the state has in regards to the SIS specifically? The concern is that the SIS generally brings in multiple individuals from multiple households. Also, the expected PPE is a mask, face shield, eye protection, gloves and a mask. Will the integrity of the assessment be affected due to a diminished level of understanding (hard to understand someone through all layer of PPE and a SIS can take up to 2 hours)?

ANSWER: Each CMHSP has a reopening plan they are following; please be sure to review that. Additionally, MDHHS has issued a residential care epidemic order that would relate for any assessor that may attempt to complete a SIS assessment in a beneficiary's home. This order requires numerous conditions be met, including social distancing, restricting movement in the facility of the assessor, as well as testing where risk levels are at C or D. This order, effective on October 26, 2020 and effective until lifted, should be review

closely and carefully. Lastly, it is wherever possible, CMHSPs should weigh the risks associated with potential transmission of the coronavirus. A complete list of new MDHHS Epidemic Orders can be found here: https://www.michigan.gov/coronavirus/0,9753,7-406-98178_98455-533660--,00.html

Additional Update: The March 3, 2021 memo "Expectation of the Provision of Face-to-Face Services" notes: " The clinical rationale for the modality used, including face-to-face, or the use of telephonic or virtual services shall be made with input from individual(s) served and must be documented on an individualized basis. Such rationale shall be reviewed and updated regularly as the individual's needs and the public health crisis evolves. Face to face services must be provided unless they cannot be provided safely, or if the family specifically requests telehealth services; either instance should be well documented. Individuals can refuse face-to-face services and that should also be documented. If the CMHSP denies face to face service provision when requested strong documentation would be needed."

Also review the guidance in the March 19, 2021 Gatherings and Face Mask Order which further delineates rules surrounding indoor and outdoor gatherings: Coronavirus - March 19 - Gatherings and Face Mask Order (michigan.gov). Work should be completed remotely unless it is strictly necessary for an employee to be in person to complete their job duties. See **MDHHS's Guidance for Employers (Nov. 6, 2020)** and **MIOSHA's Emergency Rules (Oct. 14, 2020).** Behavioral health services and activities specified in an individual plan of service (IPOS) for persons with disabilities are considered medical treatment under this Order and are not restricted by this Order's gathering limits. This includes in-person services provided in the home, in communities, and at day centers.

QUESTION: On March 20th MDHHS' BHDDA recommended suspending in person SIS assessments until May 31st to minimize non-essential contact due to the COVID-19 pandemic, I was wondering if this recommendation has been extended?

UPDATED **ANSWER:**
The March 3, 2021 memo "Expectation of the Provision of Face-to-Face Services" notes: " The clinical rationale for the modality used, including face-to-face, or the use of telephonic or virtual services shall be made with input from individual(s) served and must be documented on an individualized basis. Such rationale shall be reviewed and updated regularly as the individual's needs and the public health crisis evolves. Face to face services must be provided unless they cannot be provided safely, or if the family specifically requests telehealth services; either instance should be well documented. Individuals can refuse face-to-face services and that should also be documented. If the CMHSP denies face to face service provision when requested strong documentation would be needed." Flexibilities around the use of telehealth services continue to be an option.

Also review the guidance in the March 19, 2021 Gatherings and Face Mask Order which further delineates rules surrounding indoor and outdoor gatherings: Coronavirus - March 19 - Gatherings and Face Mask Order (michigan.gov). Work should be completed remotely unless it is strictly necessary for an employee to be in person to complete their job duties. See **MDHHS's Guidance for Employers (Nov. 6, 2020)** and **MIOSHA's Emergency Rules (Oct. 14, 2020).** Behavioral health services and activities specified in an individual plan of service (IPOS) for persons with disabilities are considered medical treatment under this Order and are not restricted by this Order's gathering limits. This includes in-person services provided in the home, in communities, and at day centers.

SKILL BUILDING/COMMUNITY LIVING SUPPORTS

QUESTION: Michigan Provider Medicaid states that a person needs to participate in skill building assistance "several hours per day, one or more days per week." While this is able to be supported in the face to face model. "Several hours per day" is extremely hard to attend to for folks with disabilities using telehealth. Has the "several hours per day, one or more days per week," been suspended during the pandemic or while receiving this service via telehealth?

ANSWER: Per MSA Bulletin 20-58, under Person-Centered Plans/Individual Plans of Service (IPOS); "The PIHP will ensure the person-centered service plan is modified to allow for additional supports and/or services to respond to the COVID-19 pandemic. In addition, the PIHP will extend pre-existing person-centered service plans and their amendments. For required in-person visits for case management/supports coordination and provider assessment/monitoring activities, MDHHS expanded telehealth options as described in Bulletin MSA 20-12. The specificity of such services, including amount, duration, and scope, will be appended as soon as possible, but no later than 30 days to ensure that the specific service is delineated accordingly to the date it was rendered." If you are not providing what is currently authorized in the PCP, then an adverse benefit determination notice will need to be sent to the beneficiary. It appears as though CLS services were being provided in lieu of skill building during the pandemic; this may be a strategy to consider continuing until the time when skill building cab be offered in the community in the amount, scope, and duration necessary.

SUBSTANCE ABUSE PREVENTION AND TREATMENT

REOPENING

QUESTION: We have been doing just phone and tele sessions with our outpatient clients. We are looking at resuming face to face if the client is comfortable coming into the office. We have put a protocol in place to ensure proper precautions are taken. Are there any guidelines in place through the state I must include?

ANSWER: Every day, new information is released regarding how best to navigate the coronavirus pandemic. This includes how to safely reopen Michigan businesses and services and best practices for COVID-19 mitigation. There is no "one size fits all" approach to reopening, and protocols will differ based on locally specific variables (e.g. population concentration, building size, interior space arrangements, etc.). Risk assessments and protocols associated with reopening should be developed prior to a resumption of office-based services.

To assess reopening risks and develop protocols, Substance Use Disorder (SUD) treatment providers should consult with their local health departments, healthcare professionals, MSHN liaisons, and MDHHS guidance to determine a plan that best fits to reopen in a manner and at a time that is safe for agency staff and persons served. The CDC regularly issues guidance as well, most recently here on May 28, 2020. This includes updated recommendations for employers responding to COVID-19 and those seeking to resume business operations. The CDC states that "resuming normal or phased activities presents an opportunity to update your COVID-19 preparedness, response, and control plans. All employers should implement a plan that is specific to your workplace, identifies all areas and job tasks with potential exposures to COVID-19,

and includes control measures to eliminate or reduce exposures. Providers can also reference the OSHA COVID-19 guidance here for more information on how to protect workers from potential exposures. Provider plans should include activities to prevent and reduce transmission among employees, maintain healthy business operations, and maintain a healthy work environment.

MDHHS has divided Michigan into Regional Healthcare Coalitions, as organized by the Michigan Emergency Preparedness Regions. MSHN's 21 counties fall into Regions 1, 3 and 6. For contact information click here.

STATUS OF TRAININGS

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

ANSWER: MDHHS and MSHN trainings are planned for virtual formats for the foreseeable future to avoid the risk of in-person gatherings during the pandemic. MSHN supported trainings can be found in the weekly constant contact newsletter. MDHHS virtual training opportunities can be found on the CMHAM website https://cmham.org/education-events/conferences-training/

QUESTION: What is the status of GAIN trainings?

ANSWER: MDHHS has offered the PIHPs the opportunity to evaluate the available options for a statewide assessment. In August, the PIHPs recommended the ASAM Continuum to MDHHS as a replacement of the GAIN-I-CORE as the statewide assessment. MDHHS continues to take this recommendation under advisement but has not provided feedback due to FY21 budget considerations. When MDHHS does provide further guidance, MSHN will be sending details out to the SUD provider network.

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: Online testing is now available. Susan at MCBAP has confirmed that they are back on track with their normal review and approval timeline for credentials.

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 MDHHS Epidemic Orders 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.

QUESTION: Guidance on Recovery Homes says we should offer "private rooms if possible." Should we allow admissions into rooms with more than 1 bed or would you prefer we leave beds open to adhere to the "private room" precaution?

ANSWER: If space allows, then it would be ideal to admit a new person into a private room for a 2-week period to ensure they are not symptomatic. After the 2-week period, and the person is showing no signs or symptoms of the COVID-19 virus, then the person can be moved into a shared room. Even in shared rooms, 6-foot distance should be maintained wherever possible. In general, recovery homes should follow guidance around social distancing, CDC guidelines, the MDHHS Epidemic Orders and related COVID 19 guidance.

QUESTION: How do Recovery Home staff monitor residents' temperatures given the shortage of thermometers?

ANSWER: We understand there are shortages on many items. Most stores will restock thermometers eventually so please keep trying.

QUESTION: Can House Leaders (i.e. designated residents who are in leadership role) perform temperature checks and how do they maintain Social Distancing?

ANSWER: MSHN supports utilizing the House Lead taking temperatures and documenting any concerns. To maintain safe Social Distancing, use the process below:

- House Leader places the thermometer on the kitchen table and steps back.

- The resident self-administers the temp check.
- Resident puts the thermometer back on the kitchen table and steps back.
- The house leaders can then view the temp (with gloves on) and disinfect thermometer.
- Then call the next person and repeat.
- Keep a checklist to note whose temps were taken and were normal (don't need to record exact temp)
- If there's a fever, quarantine individual and stay vigilant for other symptoms, and contact public health department.
- People who are currently working in the community should continue to observe all CDC guidelines, the MDHHS Epidemic Orders and related COVID 19 guidance.

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 be changing?

ANSWER: The UM Discharge Report is required to be submitted by the 2nd Friday of each month. If a provider organization has difficulty meeting this reporting requirement due to circumstances related to COVID-19, please notify the MSHN UM department through REMI secure messaging or via email: um@midstatehealthnetwork.org

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 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. However please note that according to SAMHSA Federal Guidelines for Opioid Treatment Programs and 42 CFR 8.12(f) (6) OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient, in maintenance treatment, in accordance with generally accepted clinical practice. There has not been guidance issued during COVID-19 that reduces or suspends these minimal drug testing requirements.

Residential: COVID Test Prior to Admission

QUESTION: Are residential and withdrawal management providers allowed to request that potential clients provide a negative COVID test prior to admission?

ANSWER: Yes, this is permissible. However, keep in mind that a negative COVID test is not foolproof. An individual who provides a negative COVID test may have taken the test during the incubation period so the results offer a false negative. Similarly, a client can be exposed and infected during the lag between the test date and the date that they received the results. A study published in the Annals of Internal Medicine revealed the following: Over the 4 days of infection before the typical time of symptom onset (day 5), the probability of a false-negative result in an infected person is 100% on day 1 decreasing to 67% on day 4. On the day of symptom onset (if the person is symptomatic), the median false-negative rate was 38% which decreased to 20% on day 8 (3 days after symptom onset) then began to increase again, from 21% on day 9 to 66% on day 21. Ideally, an individual would take a COVID test and then quarantine for 14 days. Providers can only be assured of a quarantine's fidelity by admitting the individual and doing the quarantine in-house.

MSHN and MDHHS therefore recommend having designated rooms where people can quarantine in a safe environment, can receive medically necessary treatment via telehealth services and remain separated from staff and other residents.

Residential: Service Hours

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

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.

QUESTION: With the progression of COVID-19, we are running into more complications with staffing. Are we required to meet 20 clinical (core) hours per week at this time?

ANSWER: The requirement for core hours remains in place, but OROSC has given guidance allowing for creative and alternative modalities to meet those core hours. Online resources like didactic workbooks or online recovery-oriented curricula can be used as well as using telemedicine to connect with offsite clinical staff. When using alternative means to meet core hours, please document in the client chart the rationale for use of alternative modalities. If support or creative brainstorming is needed, please reach out to the Treatment Specialist that you work with or to Shannon Myers, MSHN's lead for residential providers (shannon.myers@midstatehealthnetwork.org).

QUESTION: With regard to residential clients and COVID-19; we are quarantining the client for the first 72 hours to ensure they're asymptomatic and are wondering how we go about this with regard to billing. An option would be to charge only room and board for the first three days of their stay. If they were to exhibit symptoms, we would discharge them until they become symptom free. If no symptoms were detected, they would engage in therapeutic activities to meet the 20 hour per week requirement.

ANSWER: MSHN supports the provider's suggested option. However, if there are services being provided while in quarantine, then the provider could also bill the per diem rate. In addition, MSHN provided the above Q&A related to other flexibilities for required hours.

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.

Homeless

QUESTION: If a MSHN SUD consumer is homeless and tests positive for COVID 19, what would be your recommendations to get them back to residing county and quarantined? Does MSHN have designated quarantine sites for homeless population? How will client get transported back to county of residence? Also, once quarantine is completed, what will be the plan for getting consumer SUD treatment?

ANSWER: If someone receiving SUD treatment out of region, homeless or otherwise, tests positive for COVID 19, providers should immediately consult with their local health department to receive guidance. Depending on the person's medical condition, discharge may not be recommended. If unable to discharge, the ASAM Infection Control and Mitigation Strategies in Residential Treatment Guidance Document gives specific directions for safely quarantining the person in a residential facility. If medically cleared for discharge, please contact our UM department at 844.405.3095. MSHN does not have quarantine shelters for the homeless population, but we will work to place the individual in a place that's safe for him/her and for others in that location. Transportation assistance will be reviewed on a case-by-case basis contingent on availability of PPE for safe transport.

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:
Given the reduction of Block Grant funding in FY21 it is important to ensure that individuals seeking withdrawal management and residential services are screened for transportation barriers when scheduling new admissions for your programs. If an individual does not have access to transportation, please offer the person a referral to alternate programs closer to their county of residence. A complete directory of MSHN-contracted service providers by County and Level of Care can be found on the MSHN Website HERE. If necessary, Greyhound transportation may be used as a final resort if other options are not available. Prior approval should be obtained from the MSHN UM Department for any method of transportation other than Greyhound bus (mileage, gas cards, etc). MSHN will work with providers to attempt to find the least costly solutions to meet individuals' transportation needs however it may not be possible to provide transportation assistance in all cases due to limited block grant funding. Please contact the MSHN UM Department at 1-844-405-3095 with questions or for assistance identifying options for individuals with transportation barriers.

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)

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?

UPDATE **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
- MSA Policy 20-30-COVID-Response: Relaxing Face-to-Face Requirement (Update); expands flexibilities related to face-to-face requirements, issued November 4, 2020

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

UPDATE **ANSWER**: 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 20-13 – COVID 19 Response: Telemedicine Policy Expansion; PIHP/CMHSP Implications, issued March 20, 2020
- MSA Policy 20-30-COVID-Response: Relaxing Face-to-Face Requirement (Update); expands flexibilities related to face-to-face requirements, issued November 4, 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. Please refer to the code chart here on the MSHN website.

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 could not 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 **MDOCreferrals@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.

MDOC Consents

QUESTION: What do we do if the client is unable to sign the release of information?

UPDATED ANSWER:

- The client must sign the release of information (MDHHS 5515).
- If the client is unable to sign the release to due to COVID-19/coronavirus related issues ONLY, then agents can receive verbal consent from the client. The agent must complete the release as normal but write, "Verbal consent given" and the date where the client usually signs.
- This is only a temporary allowance due to COVID-19. Releases of information will be required once the health emergency is over.

To provide a bit more context to our allowance for verbal consent. If verbal consent is obtained to send a referral for the client, this does NOT suffice for ongoing releases during the treatment process. While verbal releases have been allowed for other services, substance use disorder services are still dictated by federal codes that do NOT allow for ongoing releases unless a signed document is on file. Once the client is engaged in services, they will be asked to sign the release of information to allow for full disclosure of the treatment process.

MDOC Client Phone Access

QUESTION: What do we do if the client cannot call the MSHN UM Department?

ANSWER: In certain situations, in which the client is unable to access a phone due to COVID-19/coronavirus related issues, MSHN UM Department can assist in getting the client connected to treatment. Please note the issue in accessing a phone in the email sent with the referral and MSHN UM staff will reach out to assist.

MDOC Referrals

QUESTION: We wanted direction from you on how you would like us to handle any of your (MDOC) referrals that test positive for COVID-19.

ANSWER: MSHN recommends that if the Provider is unable to bring a client into services that was referred by MDOC agents, then they should contact the referring agent immediately (with release) and let MSHN know by the next business day. MSHN will then follow up with the agent to see what more needs to be done for that client.

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 . Download the form here. The form should cover the provider's anticipated loss revenue for the timeframe being requested. This information will be reviewed by MSHN for reasonableness based on prior claims utilization.

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.

Approved requests will be paid based on MSHN's existing payment schedule. Payments are intended to cover operational expenses since there will be a decrease in service delivery. No provider repayment is expected.

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

QUESTION: My agency has qualified for the temporary shift to cost reimbursement from FFS. My understanding is that the temporary switch covers services we have provided from March 16 - June 1, 2020. Is there any other information about provider expectations past June 1, 2020? Is there going to be a potential extension of the cost reimbursement exception? What should we plan to do as an outpatient provider come June 1?

ANSWER: Providers should submit requests for cash assistance using the attached form located here. MSHN will consider the request based on available resources. Please see the guidance above for further clarification.

Project Assert

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

UPDATED **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.

If a providers Project ASSERT program has not returned to the ED or is experiencing low utilization of on-call supports, please contact the providers lead treatment specialist to consult on opportunities to re-tool the program on a temporary or long-term basis to support the community.

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 by SAMHSA on 3.16.2020 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. Additional OTP Essential Services Dosing Guidance was issued by MDHHS Behavioral Health and Developmental Disabilities Administration (BHDDA) on 4.10.2020 and can be found on the MSHN COVID-19 Website

OTP: Direct Care Worker

QUESTION: Can staff in Opioid Treatment Programs (OTPs) receive the additional compensation that Community Mental Health Direct Care Workers ($2.00 per hour hazard Pay) as the MAT's have to stay open to medicate patients? This would include nurses and front desk staff who have face-to-face patients can receive services as well as being there to coordinate and make sure intakes continue. This would only include the nurses and front desk.

ANSWER: An increase in hourly rates for OTP staff is not available at this time. Staff that provide face-to-face services for daily methadone dosing should be implementing social distancing precautions, using gloves and masks, disinfecting surfaces between dosing, etc. Financial support can also be requested to assist with provider stabilization as needed.

Methadone Treatment: Identification/Verification of ID

QUESTION: **Is there a waiver on identification verification given Secretary of State being closed?**

ANSWER: Methadone Treatment Providers usually require verification of ID at admission to in order to run a MAPS report (Michigan automated prescription system) and correctly confirm someone's identity before dispensing a controlled substance. Given the COVID-19 pandemic, MAT providers are encouraged to work with potential clients to verify identity via other appropriate means such as social security card, mail/bills addressed to the person, a rental/lease agreement, etc. if they do not have state identification and are unable to obtain state identification.

- Individuals must, to the best of their ability, complete a vehicle registration or license renewal online at www.michigan.gov/sos/ during the declared states of emergency and disaster.
- Compliance with section 2 of 1972 PA 222 (state personal identification card), as amended, MCL 28.292 is expected in the absence of a driver's license.

Additionally, according to Secretary of State FAQ - https://www.michigan.gov/documents/sos/COVID-19-OFFICE-CLOSURE-FAQ_684644_7.pdf

Customers can still complete certain transactions online at www.Michigan.gov/ExpressSOS, although processing may be delayed.

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.

Women's Specialty Internet/Phone

QUESTION: I am inquiring if we can purchase phone minutes for our Women's Specialty clients in order for those clients to have availability to talk with their clinician. Many of our WSS clients do not have zoom capabilities due to wifi service issues in rural areas, and do not want to use up their phone minutes on a telephone therapy session. Is this something we could purchase for them?

UPDATE ANSWER: MSHN appreciates the efforts its Providers are taking to ensure continuity of care, however we are unable to reimburse for phone minutes at this time. Future considerations may be given if data supports a decline in the number of services delivered based on individuals not having sufficient phone minutes to seek care. Other resources for cell phone providers can be located on the MSHN website **here**.

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?

UPDATED **ANSWER:** During the period of March through September MSHN, allowed all providers to pay staff to develop virtual skills. In FY21, all paid staff should run support groups on a virtual platform.

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?

UPDATED **ANSWER**: Cost reimbursement programs should be billed based on costs incurred. When evaluating utilization and other progress indicators, MSHN has decreased required direct service hours for FY21. MSHN ask all providers to follow their COVID 19 Fall Plans submitted in September.

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

UPDATED **ANSWER**: Given all the current closures, MSHN understands that your direct hours will be lower than planned. As such, all prevention and community recovery providers required direct hours (those put into MPDS) have been reduced for FY21. MSHN requested COVID-19 from all providers in September, these plans should be followed as written. Plans are based on your identification of services being face-to-face, virtual or a hybrid of the two. Contract amendments were sent out outlining the required direct service hours (those entered into MPDS) for each type of service. In FY21 Additional Hours Reports will not need to be completed, as MSHN prevention staff will just be tracking direct services entered into MPDS