Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 23-20

Distribution: All Providers

Issued: April 12, 2023

Subject: COVID-19 Response: Reversal of Temporary COVID-19 Relaxation of Face-to-Face Requirement Policies and Update to Face-to-Face and In Person Definitions

Effective: May 12, 2023

Programs Affected: Medicaid, Healthy Michigan Plan

Purpose

This bulletin notifies providers of the intent by the Michigan Department of Health and Human Services (MDHHS) to discontinue the temporary COVID-19 relaxation of face-to-face policies at the end of the Public Health Emergency (PHE). The temporary policies impacted by this bulletin are MSA 20-12, MSA 20-30, the MI Care Team Health Action Plan Telemedicine Coverage section of MSA 20-42, and the Health Home section of MSA 20-58.

PHE Unwind

The purpose of the temporary COVID-19 policies MSA 20-12, MSA 20-30, part of MSA 20-42, and part of MSA 20-58 was to relax the face-to-face requirements of assessments during the PHE to protect the health and welfare of beneficiaries while maintaining access to services. Effective May 12, 2023, MDHHS is terminating the above-mentioned policy bulletins.

Note: Policy bulletin MMP 23-10, issued March 2, 2023, discusses telemedicine allowances in effect post-federal PHE, including discontinued and adapted temporary bulletins.

Updated Definitions for "Face-to-Face" and "In Person"

During the PHE, the Centers for Medicare & Medicaid Services (CMS) updated their definition of "face-to-face" to allow for greater flexibility and access to services. This bulletin provides clarification for the following definitions of "face-to-face" and "in person."

Face-to-face: an encounter that can be either in person or using telehealth (simultaneous audio and visual technology).

In person: an encounter that must be completed with beneficiary and provider physically together in the same location and is **not** allowed through telehealth.

As a result of the updated "face-to-face" and "in person" definitions, several programs have made policy changes to reflect their program requirements. These policy changes are reported in the table below and updates to the MDHHS Medicaid Provider Manual to incorporate these changes will be made as indicated:

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's SED HCBS Waiver Appendix	2.2 Family Home Care Training	Family Home Care Training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and to help the child remain at home. All family training must be included in the child's IPOS and must be provided on a face-to-face basis ~~(i.e., in person and~~ with the family present~~)~~.	Removing "in person" to allow for telehealth flexibility.
Children's Special Health Care Services	9.3 Case Management Benefit	Case Management services address complex needs and services and include an initial in-person ~~face-to-face~~ encounter with the beneficiary/family.	Changing from "face-to-face" to "in-person" for initial encounter
Children's Special Health Care Services	9.7.A. Explanation of Services	Same day~~, face-to-face~~ care coordination by all of the providers who saw the beneficiary at each appointment allows for immediate discussion, negotiation, coordination and duty assignment. The family does not need to interpret information from one provider to the next which risks misunderstanding as in the usual service methodology.	Removing "face-to-face" from the care coordination service.
Children's Special Health Care Services	9.7.C.1. Initial Comprehensive Evaluation	The Initial Comprehensive Evaluation is performed in person during the CSHCS beneficiary's first visit to the CMDS clinic.	Requiring initial comprehensive assessment to be completed in person.
Children's Special Health Care Services	9.7.C.2. Basic and Ongoing Comprehensive Evaluation	Basic and ongoing comprehensive evaluation is conducted with established CMDS patients. The evaluation(s) may include the entire CMDS clinic staff composition or as deemed appropriate by each CMDS clinic Medical Director per visit and is documented in the CMDS POC. At least one visit per year must be conducted in person.	Adding requirement that at least one visit per year must be in person.
Home Help	4.2 Temporary Residence Outside of Michigan	~~A face-to-face~~ An in-person comprehensive assessment with the ASW in the client's home is required to authorize an increase in services or the continuation of services beyond the client's six-month review date.	Changing "face-to-face" to "in-person" and adding required location for the assessment.

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CHAPTER	SECTION	CHANGE	COMMENT
Home Help	5.3 Comprehensive Assessment	An ASW determines the client's need for Home Help services during a ~~face-to-face~~ comprehensive assessment ~~completed in the client's place of residence~~. The ASW issues a Time and Task to communicate to the client and provider the services that are authorized. (Refer to the Providers [Provider Payments] Section of this chapter for more information.)	Removing "face-to-face" and location to accommodate different types of assessments and settings in subsequent sections.
Home Help	5.3.A. Initial Comprehensive Assessment	Prior to case opening, an applicant must participate in an in-person comprehensive assessment with an ASW in the applicant's home. The purpose of the comprehensive assessment is to determine the applicant's eligibility for Home Help services.	Adding new section to clarify initial assessment must be in person.
Home Help	5.3.~~A~~B. Six-Month Review~~s~~	Every six months, the client's comprehensive assessment must be updated during an in-person review with the ASW in the client's home. ~~The client must, at a minimum, participate in a face-to-face review with the ASW in the client's place of residence every six months. If a client requests an increase in services or moves to a new county, a new face-to-face review and comprehensive assessment are required before payment is authorized.~~	Updating Reviews section to "in-person" and dividing the policy into several sections to distinguish between types of assessments with different contact requirements.
Home Help	5.3.C. Requests for Service Changes	A client requesting an increase in Home Help services must participate in a comprehensive assessment update with the ASW before the increase can be authorized. The update may take place in person or by phone. If the client is non-verbal or requests an in-person visit, the update must be conducted in person in the client's home.	Adding new section to clarify in person requirements for service change requests.
Home Help	5.3.D. Case Transfer to a New County	A client who moves to a new county must participate in an in-person comprehensive assessment with the ASW in the client's home before payment for Home Help services in the new county can be authorized.	Adding new section to clarify in person requirements for case transfer to a new county.

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CHAPTER	SECTION	CHANGE	COMMENT
Home Help	5.3.E. Requests for Service Changes	A client who requests a change in Home Help services must participate in a new review and comprehensive assessment with the ASW before payment can be authorized. The review and comprehensive assessment may take place in person or by phone. If the client is non-verbal or requests an in-person visit, the review and comprehensive assessment must be conducted in person in the client's home.	Adding new section to clarify face-to-face requirements for service change requests.
Home Help	8.6.B. Caregiver Interviews	At the start of service provision and at least once per year, the interview must be held ~~face-to-face~~ in person with the ASW. If phone or virtual (audiovisual only) contact was made at the last interview, ~~a face-to-face~~ an in-person contact with the ASW is mandatory for the next interview.	Changing "face-to-face" to "in person" and adding "virtual (audiovisual only)"
MI Choice Waiver	6.3 Assessment	The MI Choice program has established the Resident Assessment Instrument – Home Care (iHC) as the approved assessment instrument for assessing the functional status of participants. The iHC Assessment System, consisting of the iHC and Clinical Assessment Protocols (CAPs), is the basis for the MI Choice assessment. SCs perform a comprehensive evaluation including assessment of the individual's unique preferences; physical, social, and emotional functioning; medication; physical environment; natural supports; and financial status. The SC must fully engage the participant in the interview to the extent of the participant's abilities and tolerance. The initial assessment must be conducted in person.	Addling language to require the initial assessment to be "in person"

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CHAPTER	SECTION	CHANGE	COMMENT
MI Choice Waiver	6.7 Reassessment	Reassessment provides a scheduled, periodic ~~in-person~~ face-to-face reexamination of participant functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the participant PCSP. SCs must provide a~~n in-person~~ face-to-face reassessment to program participants within 90 days of the initial assessment or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e., death of a primary caregiver). Reassessments may be completed virtually (audiovisual) **only if** the participant chooses that method. SCs must provide a subsequent ~~in-person~~ face-to-face annual reassessment to participants or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e., death of a primary caregiver).	Changing reassessments from "in-person" to "face-to-face" to allow for telehealth flexibility.
MI Health Link	5.1.B. Assessment Requirements	During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for MI Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The in-person ~~face-to-face,~~ comprehensive assessment is the basis for determining and authorizing the amount, scope and duration, and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration, and payment of services. The reassessment must be in person ~~face-to-face~~.	Changing assessments from "face-to-face" to "in person"

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CHAPTER	SECTION	CHANGE	COMMENT
MI Health Link	7.7 Care Planning IICSP Monitoring	The ICO will make contact with the individual to inquire if the IICSP continues to meet the individual's needs. This contact may be telephonic, unless in-person contact is requested by the individual. For high-risk Enrollees, the IICSP review must be completed in person at least quarterly. For moderate-risk Enrollees, at least every other IICSP review must be completed in person. Low-risk Enrollees must be offered the opportunity for an in-person IICSP review. If the low-risk Enrollee does not wish to have an in-person IICSP review, the ICO Care Coordinator may conduct a telepresence or telephonic visit with the Enrollee. The ICO must update the individual's IICSP at least annually and more frequently if conditions warrant, or if an individual requests a change.	Adding language to reflect the face-to-face/in person requirements for different risk level Enrollees.
Nursing Facility Level of Care Determination	1 General Information	An ~~face-to-face~~ LOCD is an in-person meeting between the qualified and licensed health professional and the individual seeking functional eligibility	Removing "face-to-face"
Nursing Facility Level of Care Determination	3.1 LOCD Assessment Requirement for Reimbursement	The LOCD must be conducted in person ~~face-to-face~~ by a qualified and licensed health professional.	Changing from "face-to-face" to "in person"
Nursing Facility Level of Care Determination	3.3 Initial LOCD Assessment	The LOCD must be conducted in person ~~face-to-face~~ by a qualified and licensed health professional (as defined in the Persons Authorized to Conduct the LOCD subsection) before the provider is eligible for Medicaid reimbursement for services rendered to the beneficiary.	Changing from "face-to-face" to "in person"
Nursing Facility Level of Care Determination	3.5 LOCD Start and End Dates	All LOCDs must be entered in CHAMPS within 14 calendar days from the date the qualified and licensed health professional conducted the in-person ~~face-to-face~~ LOCD.	Changing from "face-to-face" to "in-person"
Nursing Facility Level of Care Determination	3.7 Ongoing Functional Eligibility	When a provider possesses information that a beneficiary may no longer meet eligibility, the provider must conduct an in-person ~~face-to-face~~ reassessment.	Changing from "face-to-face" to "in-person"
Nursing Facility Level of Care Determination	3.8.B. Passive Redetermination Process	The initial LOCD for a beneficiary must be conducted in an in-person ~~face-to-face~~ meeting by a qualified and licensed health professional.	Changing from "face-to-face" to "in-person"

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	3.8.D. Need to Conduct a New LOCD	For the Doors that the passive determination is unable to assess, the provider must conduct an in-person ~~face-to-face~~ LOCD prior to the current LOCD End Date. The provider must conduct a new ~~face-to-face~~ LOCD prior to the End Date and enter it in CHAMPS within 14 days of the conducted date. When the passive redetermination applies but the process cannot confirm eligibility based upon MDS or iHC assessment data, CHAMPS will create a LOCD Door 87 with an End Date 45 days from the date that record is loaded in CHAMPS, or until the current End Date, whichever is earlier. When the passive redetermination process continuously confirms that the beneficiary meets LOCD criteria, it is possible that the beneficiary will not require another in-person ~~face-to-face~~ LOCD because the passive redetermination process confirms LOCD eligibility and creates a new LOCD with a new 365-day End Date. In addition, providers must conduct an in-person ~~face-to-face~~ LOCD when there is a significant change in the beneficiary's condition, as defined by the program.	Changing from "face-to-face" to "in-person"
Nursing Facility Level of Care Determination	4 Nursing Facility Level of Care Determination Criteria	The LOCD should be an accurate reflection of an individual's current functional status. This information is gathered in an in-person ~~face-to-face~~ meeting by speaking to the individual and those who know the individual well, observing the individual's activities, and reviewing an individual's medical documentation.	Changing from "face-to-face" to "in-person"

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	4.10 Door 87: Eligible Pending In Person ~~Face-to-Face~~ Reassessment	The passive redetermination process could not confirm eligibility. The provider has 45 days from the date of the passive redetermination or until the current End Date, whichever is earlier, to conduct a new in-person ~~face-to-face~~ assessment.	Changing from "face-to-face" to "in-person"
Nursing Facility Level of Care Determination	5 Informed Choice	All Medicaid-funded LTSS programs are required to make program information available to individuals at admission/enrollment, at an in-person ~~face-to-face~~ reassessment, and upon request from the individual or their legal representative.	Changing from "face-to-face" to "in-person"
Pharmacy	4.1 Offer to Discuss	If practical, the offer to counsel must be in person ~~face-to-face~~ and verbal.	Changing from "face-to-face" to "in person"
Pharmacy	21.4 Eligible Recipients	MTM services must be provided in person ~~face-to-face~~ with the beneficiary whenever possible. If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the beneficiary's behalf.	Changing from "face-to-face" to "in person." The emphasis on this section is in person – but left "face-to-face" in the second reference since face-to-face is allowed
Pharmacy	21.6 Location Requirements	These services must be provided in person ~~face-to-face~~ in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings.	Changing from "face-to-face" to "in person"
Pharmacy	21.7 Telepractice for MTM Services	In the event that the beneficiary is unable to physically access an in-person ~~face-to-face~~ care setting, an eligible pharmacist may provide MTM services via telepractice.	Changing from "face-to-face" to "in-person"
Pharmacy	7.2 Core Elements of Family Supports Coordination	• a ~~face-to-face~~ comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care.	Removing "face-to-face" to define in the next section

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CHAPTER	SECTION	CHANGE	COMMENT
Special Programs [Flint Family Supports Coordination Services]	7.2.A. Initial/Annual Comprehensive Assessment Visit	All comprehensive assessment visits, including the initial in-person ~~face-to-face~~ comprehensive assessment visit, must be conducted by a qualified licensed nurse or social worker with the beneficiary in the beneficiary's home or primary place of residence. The purpose of the comprehensive assessment visit is to gather sufficient information to develop an individualized Plan of Care for the beneficiary and to ensure that all other eligible individuals in the household are identified for further screening. Initial comprehensive assessments must be conducted in person while re-assessments may be conducted face-to-face. It is expected that face-to-face re-assessments are performed annually; however, the frequency should be based on the needs and circumstances of the beneficiary and/or family.	Changing language for initial assessment from "face-to-face" to "in person." Adding language about initial vs. re-assessment requirements. Changing "assessments" to "re-assessments" in the second paragraph.
Special Programs [Flint Family Supports Coordination Services]	7.2.B. Development of the Plan of Care and Documentation	During or immediately following the ~~face-to-face~~ initial comprehensive assessment visit, a Plan of Care must be developed for beneficiaries who agree to participate in Family Supports Coordination services, with the active participation of the parent(s)/legal guardian(s) when applicable.	Removing "face-to-face"
Special Programs [Flint Family Supports Coordination Services]	7.4 Covered Supports and Services	A maximum of six (6) ~~face-to-face~~ visits per year will be reimbursed for each eligible beneficiary as follows:	Removing "face-to-face" as this is defined in other sections above.

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CHAPTER	SECTION	CHANGE	COMMENT
Special Programs [Flint Family Supports Coordination Services]	7.8.A. Initial/Annual Assessments	~~Face-to-face a~~A~~ssessment visits are to be billed using HCPCS code T2024 for an individual or family. This includes reimbursement for the development of a Plan of Care for one individual. HCPCS code T2024 with modifier TT (additional patient) should be billed for each additional individual Plan of Care that is developed from the assessment visit. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served). Assessment visits must be in the home or "home-like" environment. One ~~face-to-face~~ initial/annual assessment visit per year per family/household is allowed. Additional assessment visits beyond one per year per family/household require prior authorization.	Removing "face-to-face" language

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

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Approved

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