

## COVID-19 FREQUENTLY ASKED QUESTIONS AND GUIDANCE TO DESIGNATED AGENCIES

### DEPARTMENT OF MENTAL HEALTH

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*While the health care environment continues to rapidly evolve, the Department of Mental Health will provide as much information as possible to providers regarding how the impacts of COVID-19 effect the delivery of services. Additional detail may be necessary in some areas and guidance may change in the coming days and weeks, thus we will share further information as clarification becomes available. **If the Vermont Department of Health subsequently releases any direction that differs from the guidance below, the VDH direction takes precedence.***

## GENERAL GUIDANCE

### **COVID-19 AND MENTAL HEALTH—VERMONT DMH IS HERE.**

Mental Health Information for Individuals, Families and Providers ([RESOURCES UPDATED HERE](#))

Send Questions to: [AHS.DMHCOVID19Info@vermont.gov](mailto:AHS.DMHCOVID19Info@vermont.gov)

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## WORKFORCE

### **WORKPLACE SAFETY**

There are multiple tools for staff and independent support workers to ensure safety as much as is possible. Workers who are a part of a high-risk group should be working remotely. Workers who are still required to perform face-to-face activities should follow all safety guidelines that have been posted [here](#).

When there are questions, staff and independent support workers should consult with supervisors and supervisors must weigh the various health and safety needs of individuals to determine appropriate response.

### **ESSENTIAL HEALTHCARE WORKERS AND SERVICES**

The March 7th press release from the Governor's Office, available [here](#), defines Designated Agencies (DAs) as essential, and in the Executive Order issued March 25, 2020, all Designated Agencies, Specialized Service Agencies, residential treatment programs (PNMI), therapeutic foster parents and shared living providers are considered "healthcare service providers" and "caregivers" of essential services.

Essential Services are services that assure the health and safety of a person. Essential Services delivered in-person to a consumer may continue if the services cannot be provided in an alternate, remote way such as telehealth, telephone, or other remote platforms.

All in-person service delivery must follow guidance of this [Home-Based Service Delivery: Restart Guidance](#), updated May 15, 2020 or after.

Examples of "essential services" include:

- Emergency examinations for involuntary hospitalization
- Crisis stabilization/ hospital diversion programs
- Residential treatment programs, including group homes, staffed living and intensive residential treatment
- Therapeutic foster care/ shared living homes
- Psychiatric services
- Nursing services
- Obtaining essential home supplies related to health and sanitation

### **NON-ESSENTIAL SERVICES**

All non-essential, in-person including home-based services that do not directly contribute to health and safety shall be suspended until further notice. Non-essential services may continue if alternative, remote methods of delivery are available. The determination must be made by the provider of services and is based on individual need and level of risk.

Examples of services that may be “non-essential” for in-person delivery include the following:

- Case management/service coordination
- Community supports
- Non-urgent therapy
- Respite
- Supported employment
- Day services

### **REMOTE WORK**

If an employee cannot work remotely, consider rotating in-person work schedules so that staff are not all together at the same time when in the office. General information about novel coronavirus and precautions are available [here](#) at the Department of Health website.

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## **SERVICE DELIVERY**

### **TELEHEALTH**

Text messaging is still not a covered service under Vermont Medicaid. Please direct your questions regarding telehealth, telemedicine and temporary telephonic coverage and reimbursement to Department of Vermont Health Access, the state Medicaid authority. Their latest resources and guidance is [here](#). Providers who have questions should contact Vermont Medicaid Provider Services at 1-802-878-7871 (press 3) for assistance.

### **TRANSPORTATION OF CLIENTS**

Staff and independent support workers should not transport clients if doing so creates a greater risk to health and safety than the lack of transportation. When it is essential to provide transportation, the client should sit in the seat farthest from the driver in alignment with recommendations for social distancing.

### **DOCUMENTATION REQUIREMENTS**

It is critical to assure enough documentation is happening to provide for the safety of clients, especially at a time where meetings and updates may not be an option and providers may be relying on documentation for information. By July 1, 2020 DMH expects that agencies have utilized Emergency COVID funding and adapted to remote work well enough to provide full clinical documentation for clients. Verbal signatures can, as always, be obtained as needed. Please note “Verbal signature obtained due to COVID-19 state of emergency” in the documentation notes.

Master Agreement performance measure and value-based reporting will have deadlines amended and targets will be reevaluated to consider whether data should be reporting only to account for expected practice changes. These edits will be reflected in Master Agreements.

Bed Board reporting is still considered crucial and needs to be maintained.

#### **PROVIDER ENROLLMENT**

CMS Health Care Provider Fact Sheet addresses what the emergency declaration allows for provider enrollment. Read it [here](#).

#### **CARING FOR COVID-19 POSITIVE PEOPLE**

The Vermont Department of Health website [here](#), contains the most recent health information and guidance for health professionals on working with the COVID-19 positive population.

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#### **SUPPLIES AND EQUIPMENT**

If depletion of any COVID-19 specific resource stocks are anticipated within the next 7 days, please submit a resource request [here](#). Completion of this COVID-19 resource request form assumes facility implementation and practice of Contingency Operations Personal Protective Equipment Conservation (PPE) measures, available [here](#). PPE conservation measures are based in part on the CDC's Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response, available [here](#).

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#### **COMPLIANCE**

##### **Q: Please confirm the types of video conferencing that are HIPAA compliant.**

Please refer to the HHS guidance [here](#).

##### **Q: When is adherence to HIPAA necessary – i.e. is HIPAA compliance required for conversation between person living at an SLP and their family members?**

The Department of Mental Health is not authorized to provide legal advice on this matter, so providers should consult with their own legal resources.

##### **Q: What if our staff or clients test positive for coronavirus?**

Due to the current COVID-19 public health emergency, an addendum to the Critical Incident reporting requirements has been made. Designated Agencies/ Specialized Service Agencies must report known positive cases of COVID-19, within their client population or among staff who may have been in contact with the patient population.

1. Agencies must submit a verbal report by phone within 24 hours.
2. Agencies must submit electronically a written report within 2 business days.

Please send verbal or written reports to Norm McCart RN, DMH Nurse Quality Management Specialist at: <mailto:AHS.DMHquality@vermont.gov> or secure fax at: (802) 241-0100

**Q: Can quality reviews be suspended for now?**

As of July 1, 2020, the quality review process will begin again with modifications to the approach. The DMH Quality Team will be sending letters to each organization detailing the plan to restart the review process and the alternative methods, such as remote chart reviews, that will be applied.

**MEDICAL CLEARANCE AND TRANSPORTATION REGULATIONS**

**Q: There can be barriers to helping clients access inpatient care directly from the community, instead of the ED where they have increased risk of exposure. We need to have flexibility to support clients with no other transportation options to access safe transport (such as ambulance, sheriff, or Medicaid taxi) without going to the ED.**

Medical necessity is required for Ambulance transport. If there is no danger to self or others then a regular, non-emergent transport should be pursued. Information about these rides can be found [here](#).

To coordinate a Non-Emergent Medicaid Transport staff can call VPTA at 833-387-7200.

If there is a medical reason or safety issue that indicates the need for an ambulance transport, staff should contact Sandi Hoffman at DVHA for guidance on coordinating the medically necessary ambulance: [sandi.hoffman@vermont.gov](mailto:sandi.hoffman@vermont.gov) or 802-798-2186.

DMH has provided a memo [here](#) from our medical directors suggesting reducing and/or streamlining medical clearances for all levels of care – hospital, residential and crisis beds.

**Q: Can a psychiatrist provide an initial evaluation and prescribe a controlled substance over just a telephone service without access to video? One of our psychiatrists thought they read something about it having to be with video or face to face, because of the controlled substance prescription.**

The Drug Enforcement Agency has allowed doctors to use telemedicine to prescribe controlled substances since declaring a state of emergency in January 2020. This service still requires the doctor follow the telemedicine/telehealth protocol of having both video and audio capability. Psychiatrists are encouraged to regularly check the American Medical Association, American Psychiatric Association, and Drug Enforcement Agency [websites for updates](#).

**Q: Can the two-year re-assessment requirement for DMH Medicaid clients be waived for the remainder of 2020? Also, what about extending Medicaid IPC longer than currently required?**

It is expected that all eligible agencies have utilized Emergency COVID Relief Funds to secure remote access for their staff and have provided telehealth and telephone flexibilities for

services. Additionally, given the intense impact of the pandemic on individuals' psychosocial experiences, stressors, and resources, it is especially important to continue to reevaluate client's needs, strengths and symptoms during this time, as well as provide transparent treatment plan adjustments.

Therefore, as of July 1, 2020 agencies will be given 6 months to come into compliance on existing overdue assessments and treatments plans. The current goal is to be up to date on assessments and treatment plans by January 1, 2021. For assessments and/or treatment plans that are completed on an overdue date due to the pandemic, please write "*Overdue due to COVID-19 state of emergency*" in the document notes to assure the rationale is transparent for future compliance reviews. DMH will continue to evaluate this plan as the COVID -19 pandemic continues.

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## FINANCE

**Q: Because Mental Health Payment Reform will not be using the V3 modifier to identify telephonic services, how do the DA's and SSA's that are active with Mental Health Payment Reform move forward during this time?**

In collaboration with the Billing Managers the following guidance will be followed: H2017 and H2015 services will use POS code 53 (CMHC) as it has been since telephonic services have been allowed for these codes. H2011 (Emergency Services) will continue to be coded as it has been as both telephonic and in person has been allowed for this service. All other services that are approved for MHPR will use POS 99 for any telephonic services that are being provided beginning on 3/23/2020 and will continue until we are no longer shifting service provision in response to COVID-19.

**Q: What payments will be made when utilization levels drop-off below current requirements whether due to drop in demand or staff shortages?**

With DMH Case Rate/Payment Reform, through the Mental Health Case Rate model agencies are paid monthly for case rate services on a prospective basis using an annual budget and target caseload for each DA/SSA. The prospective payment is paid in lump sum at the same point each month and the entire case rate allocation is received through equal distribution over 12 months. Reconciliation occurs at the end of each calendar year based on whether agencies met their caseload targets.

This model makes DMH well poised to adjust for a substantial decrease in service utilization across the state. Community mental health agencies would still be able to count on a standard prospective payment throughout calendar year 2020, and the rules of the DMH reconciliation process would need to be modified to adapt to a substantial reduction in services related to a declaration of State of Emergency. For example, the months of impact could be removed and pro-rated based on the rest of the year's performance.

Additionally, DMH has a case rate valuation model that uses service utilization to plan for future case rate adjustments. This model can also be adapted to consider significant drops in utilization for COVID-19, mitigating the impact of a State of Emergency on future case rate development.

- DMH PROVIDERS: Programs that exist outside of DMH’s case rate are those most at risk given they do not benefit from the flexibility of the case rate as noted above.
- RESIDENTIAL/PNMI: Providers bill a daily rate that is computed by rate setting based on historical utilization and cost. This daily rate may or may not cover the cost of providing services to the individuals placed at the facility. Providers can submit a request for extraordinary financial relief (EFR) if the daily rate does not cover the cost. The state has some flexibility to approve a request that considers the cost of underutilization due to extraordinary circumstances.
- There are two adult residential facilities outside of the case rates, Second Spring North and South. Quarterly payments are sent to the provider with a year-end cost reconciliation, and any unspent funds beyond a 1.5% gain is returned to the State. If the cost of the facility is not covered by the quarterly payments, DMH has the flexibility to provide more funding as needed within available resources.

## SCHOOL-BASED SERVICES

Success Beyond Six (SB6) providers were issued a memo on March 19, 2020, updated March 26, 2020, detailing specific SB6 issues related to service delivery methods, match payments, billing and reimbursement. This document provides further updates. The Agency of Education has provided separate guidance to schools for COVID-19 [here](#).

These changes are effective during the period of Governor Scott's Declaration of State of Emergency in Response to COVID-19 and the period of CMS approved Medicaid flexibilities (currently through January 26, 2021).

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### SERVICE DELIVERY

Planning is underway for the reopening of schools in the Fall, including preparing for any combination of in-school and remote learning. When schools are open, SB6 services should be primarily provided in the school setting. The school mental health services will also need to be flexible in responding to the changing need for hybrid and remote service delivery. A workgroup with state and local education and mental health partners is reviewing the barriers and opportunities for how SB6 can be structured for such flexibility.

Designated Agencies should coordinate their plan for service delivery for the 2020/2021 school year with their LEA/SU/SD to determine how SB6 school mental health services can be flexible to meet the needs of students and schools, while also complying with all relevant requirements, including Special Education regulations where applicable. Determination of remote service delivery should be based on clinical need, family availability and ability to access supports through remote methods, and adherence to the Executive Orders located [here](#). Also see DMH Essential Services guidance and VDH guidance for [Home-Based Service Delivery: Re-Start Guidance](#).

### COVID-19 Flexibilities for Service Delivery through Telehealth and/or Audio Only

Medicaid already allows some services to be provided by phone, including Community Supports and Service Planning & Coordination which are the most commonly used services under SB6. Please direct your questions regarding telehealth, telemedicine and temporary telephonic coverage and reimbursement to DVHA, our partner and state Medicaid authority. Their latest resources and guidance are available [here](#). Providers who have questions should contact Vermont Medicaid Provider Services at 1-802-878-7871 (press 3) for assistance.

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### SB6 FINANCE AND BILLING

The State recognizes that providers may continue to experience financial difficulty as a result of the COVID-19 Executive Orders and should use the identified pathways for financial relief for providers.

### **Behavioral Intervention Program Services (BI)**

These services include Service Planning and Coordination, Community Supports and may be provided through telehealth or phone with the student and/or family in their home or chosen setting and are not required to be in-person in a school setting.

During fiscal year 2021, these services will continue under the fee-for-service structure while DMH works with DVHA, VCP/DAs and state and local education partners to consider development of a long-term BI Program Case Rate.

**School-based Clinician Services** These include Service Planning and Coordination, Community Supports, Individual and Family Psychotherapy and may be provided through telehealth or phone with the student and/or family in their home or chosen setting and are not required to be in-person in a school setting.

The minimum service threshold is lowered from 2 hours (8 units) of a qualifying service per month to 1 hour of a qualifying service per month in order to bill the monthly case rate.

### **Concurrent Education, Rehabilitation, and Treatment (CERT)**

These include Service Planning and Coordination, Community Supports, Individual and Family Psychotherapy and may be provided through telehealth or phone with the student and/or family in their home or chosen setting and are not required to be in-person in a school setting.

The minimum service threshold is lowered from 2 hours (8 units) of a qualifying service to 15 minutes of a qualifying service per day in order to bill the per diem rate.

### **Finance: Match Payments**

DA is responsible for ensuring match payments are made for the appropriate amount and within the timeline for all SB6 Medicaid billing.