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Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

DATE: UPDATED July 23, 2020

Behavioral Health Information Notice No: 20-009
Superseded by BHIN 21-046

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Opioid Maintenance Providers
California State Association of Counties Coalition of Alcohol and Drug Associations County Behavioral Health Directors
County Behavioral Health Directors Association of California County Drug & Alcohol Administrators

SUBJECT: Guidance for behavioral health programs regarding ensuring access to health and safety during the COVID-19 public emergency

REFERENCE: DHCS COVID-19 Response website

PURPOSE: Provide guidance on concrete steps counties and providers should take to minimize the spread of COVID-19, ensure ongoing access to care, and provide guidance on flexibilities given the Section 1135 waiver granted by the Centers for Medicare and Medicaid Services (CMS), effective March 15, 2020, and Governor's Executive Orders N-43-20 and N-55-20.

BACKGROUND: DHCS is issuing guidance to counties and Medi-Cal providers to assist them in providing medically necessary health care services in a timely fashion for patients impacted by COVID-19. DHCS was given authority to grant flexibility for certain requirements through Executive Order N-43-20 and N-55-20. See DHCS COVID-19 Response website for information notices related other Executive Order flexibilities related to Driving Under the Influence (DUI) Programs, Alcohol and Other Drug (AOD) programs, and residential and inpatient mental health treatment facilities.

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This Information Notice covers:

1. Behavioral health services via telephone and telehealth (5/20/20)
2. Modified requirements for DMC State Plan individual counseling visits (5/20/20)
3. 5150 evaluations and 5151 assessments (updated 7/23/20)
4. Waiving signature requirements for psychiatric medications (4/23/20)
5. Additional time to complete counselor certification requirements (4/23/20)
6. Adapting oversight requirements to prioritize patient needs and accommodate workforce challenges
7. Emergency enrollment in Medi-Cal for mental health providers (4/9/20)
8. Access to prescription medications
9. AOD residential and outpatient treatment facility flexibilities (updated 4/9/20)
10. Audits and On-site Reviews (5/20/20)
11. Process to request fee reductions or waivers (4/9/20)
12. Canceling meetings and gatherings to prevent COVID-19 transmission.

POLICY

DHCS encourages counties and providers to take all appropriate and necessary measures to ensure beneficiaries can access all medically necessary services while minimizing community spread during the COVID-19 public emergency.

1. Behavioral health services via telephone and telehealth *(5/20/20)*

Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth.

Services delivered via telehealth and telephone are reimbursable in Medi-Cal managed care (physical health care),[1] Specialty Mental Health Services (SMHS), the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the DMC State Plan system.

DHCS strongly encourages all counties to work with providers to maximize the number of services that can be provided by telephone and telehealth, to minimize community spread of COVID-19, as well as to protect the behavioral health workforce from illness.

DMC-ODS counties that have NOT previously authorized services via telehealth in their program should allow providers to bill for services via telehealth during the period of heightened COVID-19 concern. County approval of services via telehealth is sufficient; contract changes are not required.[2]

DHCS does not restrict the location of services via telehealth. Patients may receive services via telehealth in their home, and providers may deliver services via telehealth from anywhere in the community, outside a clinic or other provider site. DHCS does not

[1] DHCS has also released guidance to Medi-Cal Managed Care Plans regarding COVID-19.
[2] For more information, see MHSUDS IN 17-045.

impose requirements about which live video platform can be used to provide services via telehealth.

Specific guidance for providers regarding HIPAA and telehealth is available from the external resources listed on DHCS' Telehealth Resources page.

The U.S. Department of Health and Human Services Office of Civil Rights (HHS-OCR) has clarified that they will use enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules when providers use telehealth in good faith during the COVID-19 public health emergency. The HHS-OCR guidance states that providers can use any non-public facing remote communication product that is available to communicate with patients. Specifically, 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. However, public facing applications such as Facebook Live, Twitch, TikTok, and similar video communication applications should not be used in the provision of telehealth. Additional guidance regarding HHS-OCR's HIPAA enforcement during the COVID-19 public health emergency can be found on HHS-OCR's webpage.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has also issued guidance on 42-CFR Part 2 compliance during the emergency.

In addition, the Governor's Executive Order N-43-20 states that the administrative penalties for health care providers specified in Health and Safety Code section 1280.17, related to safeguards of health information, are suspended for health care providers as applied to any inadvertent, unauthorized access or disclosure of health information during the good faith provision of telehealth services as a result of the use of technology that does not fully comply with federal and state law during the COVID-19 emergency period.

Providers should complete service documentation in the patient treatment file in the same manner as in-person visit. The Governor's Executive Order N-43-20 states that the requirements specified in Business and Professions Code section 2290.5(b) related to the responsibility of a health care provider to obtain verbal or written consent before the use of telehealth services and to document that consent, as well as any implementing regulations, are suspended during the COVID-19 emergency period.

Services provided by telephone or telehealth may be provided and reimbursed by the following programs;[3] details for each program are described below:

[3] See State Plan – Targeted Case Management, State Plan – outpatient specialty mental health services and Drug Medi-Cal for more detail.

- ***Drug Medi-Cal Organized Delivery System:*** *(5/20/20)*

  - Starting March 1, 2020, through the duration of the emergency, the initial clinical diagnostic assessment, determination of medical necessity, and level of care can be conducted by telephone. These services may be provided by telehealth, or in-person, independent of the emergency.
  - Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
  - Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed.
    However, California's Medicaid State Plan does not require that all components of these services be provided in-person. (An example could include services via telephone for a patient quarantined in their room in a residential facility due to illness).
  - Currently, DMC-ODS individual counseling services that a provider determines to be clinically appropriate can be provided via telehealth and telephone. Beginning on March 1, 2020, and for the duration of the public health emergency, group counseling services can also be provided via telehealth and telephone in DMC-ODS counties.[4]
  - Services provided via telehealth are currently optional for counties in the DMC-ODS waiver. DMC-ODS counties that have NOT previously authorized services via telehealth in their program should allow providers to bill for services provided via telehealth during the period of heightened COVID-19 concern; DHCS approval is not required.
  - No additional billing code (e.g. modifier) is required when submitting claims for services rendered via telehealth or telephone. The service provided should be claimed with the appropriate procedure code.
  - With the exception of the Narcotic Treatment Program intake/physical for methadone maintenance, the required physical exam can be conducted via telehealth. When a physical exam cannot be secured within 30 days, it is acceptable to list the physical exam as a goal on the treatment plan. For options regarding the physical exam, please see the Intergovernmental Agreement.

- ***DMC State Plan:*** *(5/20/20)*

  - Beginning on March 1, 2020, and for the duration of the emergency, face-to-face requirements for all DMC State Plan benefits/services are modified. In order to afford providers the flexibility to safely and expeditiously render necessary care, including initial intake/assessment to determine medical necessity,

[4] Group counseling sessions may be conducted via telephone and telehealth if the provider obtains consent from all the participants and takes the necessary security precautions, in compliance with HIPAA and 42CFR Part 2.

individual and group[5] services may be provided via all forms of telehealth and telephone, regardless of originating or distant site.[6]
- Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
- No additional billing code (e.g. modifier) is required when submitting claims for services rendered via telehealth or telephone. The service provided should be claimed with the appropriate procedure code.
- With the exception of the Narcotic Treatment Program intake/physical for methadone maintenance, the required physical exam can be conducted via telehealth. When a physical exam cannot be secured within 30 days, it is acceptable to list the physical exam as a goal on the treatment plan. For options regarding the physical exam, please see Title 22 Section 51341.1.

- ***Specialty Mental Health Services:***

  - Any service, including an individual or group service,[7] that can be provided by telephone or telehealth is reimbursable in all counties (examples include mental health services, crisis intervention services, targeted case management, therapeutic behavioral services, intensive care coordination, intensive home- based services, medication support services, and components of day treatment intensive, day rehabilitation, adult residential treatment services, and crisis residential treatment services). Mental health intake/assessments may be provided through telephone or telehealth.
  - Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.

Certain services, such as crisis stabilization, day rehabilitation, day treatment intensive, crisis residential treatment services, and adult residential treatment services require a clearly established site for services and some also include in-person contact with a beneficiary in order to be claimed. However, not all components of these services must be provided in person.[8] (An example could include services via telephone for a patient quarantined in their room due to illness).
  - Providers should add the telehealth billing modifier, GT, to identify that the specialty mental health service was rendered via telehealth. (See Mental

[5] Group counseling sessions may be conducted via telehealth and telephone if the provider obtains consent from all the participants and takes the necessary security precautions, in compliance with HIPAA and 42CFR Part 2.
[6] California State Plan Amendment (SPA) 20-0024, Section D, 5 (Disaster SPA, approved 5/13/2020).
[7] Providers are still required to follow relevant privacy laws to ensure patient privacy protections.
[8] See Title 9, California Code of Regulations, Sections 1840.318, 1840.320, 1840.332, 1840.334 and the California's Medicaid State Plan: Supplement 1 to Attachment 3.1-A – Targeted Case Management (TCM) Services for Medi-Cal Beneficiaries that Meet Medical Necessity Criteria for TCM Covered as Part of the Specialty Mental Health Services Program; Supplement 2 to Attachment 3.1-B - Rehabilitative Mental Health Services (Medically Needy); and Supplement 3 to Attachment 3.1-A - Rehabilitative Mental Health Services (Categorically Needy).

Health Services Division Medi-Cal Billing Manual, page 87-94 for more information). If a county or provider is unable to configure the IT systems to accept this modifier, the modifier may be omitted during the state of emergency, until these modifications can be made. The Short Doyle system will accept and pay the claim even if the modifier is not included on the claim. During the emergency, DHCS strongly encourages all counties to allow SMHS to be provided via telehealth and telephone, and if the county systems are not set up yet to add the modifier, claims may still be submitted and processed; the lack of systems in place to add the modifier should not be a barrier to the provision of services. The place of service code is not required for outpatient services, but is required for inpatient services.

- ***Mental Health Services Act (MHSA):***

  Counties may use MHSA funding to pay for services provided via telephone or telehealth as long as the services provided are consistent with the MHSA requirements and are not able to be covered by any other source of funding.

  More information on telehealth can be found on the DHCS telehealth website.

2. Expansion of allowable DMC State Plan individual counseling visits (5/20/20)

Beginning on March 1, 2020, and for the duration of the emergency, individual counseling visits provided in DMC State Plan counties include visits focused on short-term personal, family, job/school or other problems and their relationship to substance use, in addition to the already allowable visits for the purpose of intake, crisis intervention, collateral services, and treatment and discharge planning.[9]

3. 5150 Evaluations and 5151 Assessments (updated 7/23/20)

Pursuant to W&I Code section 5008(a), evaluations under the Lanterman-Petris-Short (LPS) Act may be performed by authorized providers face-to-face, which includes evaluation services performed via telehealth. The definition of "evaluation," as specified in section 5008(a), which permits telehealth, applies throughout the LPS Act unless there is an indication otherwise (e.g., W&I Code §§ 5150, 5250, 5260, 5270.15, 5270.35, 5270.55).

Evaluations, including those provided via telehealth, may result in the release of an individual from an involuntary hold, as appropriate.

The aforementioned evaluations are billable to Medi-Cal regardless of whether they are provided in person or through telehealth as long as the individual has Medi-Cal coverage for the service and all Medi-Cal requirements are met.

[9] California State Plan Amendment (SPA) 20-0024, Section D, 2 (Disaster SPA, approved 5/13/2020).

5151 assessments, however, are not allowable via telehealth and must be in-person pursuant to Welfare and Institutions (W&I) Code section 5151, "Prior to admitting a person to the facility for treatment and evaluation pursuant to Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in-person to determine the appropriateness of the involuntary detention."

4. Waiving signature requirements for psychiatric medications (4/23/20)

The Executive Order N-55-20 waives the requirement for patient signatures for psychiatric medication consents.[10] Instead, counties shall allow a patient's verbal consent (in lieu of written consent) for receiving psychiatric medication(s), due to the difficulty of collecting signatures when services are provided via telephone or telehealth.

5. Additional time to complete counselor certification requirements (New 4/23/20)

California Code of Regulations, Title 9, §13035(f)(1) requires AOD registered counselors to obtain certification as an AOD counselor, from a DHCS recognized certifying organization, within five (5) years of the date of registration.

Under the authority of Executive Order N-55-20, DHCS shall suspend the requirement to complete AOD registration for the duration of the declaration of emergency. DHCS shall extend the AOD registrants' completion date by the same number of months that the requirement was suspended.

6. Adapting oversight requirements to prioritize patient needs and accommodate workforce challenges

The COVID-19 public health emergency may increase demands at clinical facilities during a time when staff resources may be strained. Staff may need to plan, respond, and adapt due to the changing environment, including staff or patient illness and quarantine.

DHCS encourages counties to reach out to their DHCS liaison if there are any concerns about meeting any state-mandated regulatory requirements or DHCS reporting requirements and deadlines due to the impact of COVID-19.

DHCS strongly encourages counties to minimize administrative burden and waive any additional county oversight and administrative requirements that are above and beyond DHCS and/or federal requirements during the state of emergency. Examples include converting on-site audits and site reviews to virtual desk audits, postponing audits and provider reviews that are not time-sensitive, deferring additional training or reporting requirements, and waiving minimum requirements for clinical hours per week that are above and beyond DHCS requirements (e.g., for residential facilities), to accommodate

[10] Cal. Code Regs., tit.9, § §852.

for staff shortages.

7. <u>Emergency Enrollment in Medi-Cal for Specialty Mental Health Service Providers</u> (4/9/20)

Pursuant to section 1135 of the Social Security Act (1135 Waiver) CMS has waived the enrollment requirement for SMHS providers to undergo an onsite visit per Code of Federal Regulations (CFR), title 42, section 455.432(a). Moreover, part of the enrollment process for SMHS providers includes the requirement for the provider to obtain a fire clearance prior to the onsite visit, as specified in the county Mental Health Plan (MHP) contract. As stated under the MHP contract, Exhibit E, page 12 of 16, Paragraph 7(B), DHCS may use policy letters to provide clarification and instructions to its contactors regarding implementation of mandated obligations pursuant to State and federal statutes and regulations.

In light of the many challenges counties are facing due to the COVID-19 crisis, including the inability to obtain a fire clearance, the DHCS is waiving the Medi-Cal Certification requirements for an onsite review and a fire clearance, during the approved 1135 Waiver period.
During this time, providers may be certified using the streamlined procedures outlined below:

- For initial certification of county-owned and operated providers, the County Mental Health Plan (MHP) shall submit an Application for Medi-Cal Certification (DHCS Form 1736), which includes a copy of the head of service license and Program Description for the provider.
- For re-certification of county-owned and operated providers, where the MHP conducts the onsite review, the MHP shall submit a MHP Recertification of County-Owned and Operated Providers Self-Survey Form (DHCS Form 1737), which includes a copy of the head of service license.
- For re-certification or change of address of county-owned and operated providers, where DHCS conducts the onsite review, i.e., juvenile detention center, crisis stabilization unit, day treatment and/or adding medication room(s), the MHP shall submit all updates via email to include a head of service license and Program Description, as needed.
- For initial certifications and re-certifications of contracted providers, the MHP shall submit a Medi-Cal Certification Transmittal (DHCS Form 1735).
- For DHCS tracking purposes the MHP shall note “COVID-19 Emergency Medi- Cal Certification” on whichever form is being submitted to DHCS for processing, i.e., DHCS Form 1735, 1736 or 1737.
- MHPs following these procedures will be granted enrollment for 60 days, retroactive to March 1, 2020.
- Please note that the 60-day emergency Medi-Cal Certification may be extended in 60-day increments in accordance with the 1135 waiver.
- Should the 1135 Waiver be extended, no further action will be required on behalf of the approved provider.
- Upon conclusion of the 1135 Waiver, the MHP will be required to submit any

outstanding documentation and meet all certification requirements, including the requirement for onsite review and having a valid fire clearance.
- The MHP will have 180 days from the conclusion of the 1135 Waiver to conduct the onsite review and to submit any outstanding documents, including a current fire clearance.
- If due to unforeseen circumstances a county is unable to meet the 180-day time frame the county may submit a request for an extension of up to an additional 90 days.
- All required documentation and email communication must be submitted to DMHCertification@dhcs.ca.gov.

8. Access to Prescription Medications

Since many individuals who receive Medi-Cal Specialty Mental Health and Drug Medi-Cal Services are prescribed medications to address their mental health and substance use disorder needs, counties and providers should refer to the DHCS Fee-for-Service Pharmacy Benefit Reminders and Clarifications web page for guidance in response to questions regarding dispensing policies governing the Medi-Cal fee-for-service pharmacy benefit as it relates to COVID-19.

Medi-Cal allows prescribing and dispensing of 100-day supplies of medications, including certain controlled medications. Early refills are allowed, as long as 75% of the expected duration has occurred.

9. Alcohol and Other Drug (AOD) Residential and Outpatient Treatment Facility Flexibilities (4/9/20)

DHCS will grant flexibility to Residential and Outpatient Treatment Facilities to allow ongoing access during the emergency. See Behavioral Health Information Notice (BHIN) 20-017, Alcohol and Other Drug Facilities, for more information, on the DHCS COVID-19 Response website.

10. Audits and On-site Reviews (5/20/20)

Given the physical distancing guidelines and ongoing stay-at-home orders, DHCS will not perform any county or provider behavioral health onsite audits until further notice. Additional detail is as follows:

- **Specialty Mental Health Services (SMHS):** As per guidance issued on April 23, 2020, the March through June 2020 triennial and Post-Service Post-Payment reviews will be postponed and rescheduled to occur between July through October, 2020; with the onsite conducted virtually. Thereafter, reviews may be performed virtually until further notice. If a county cannot meet the scheduled timeline due to staffing issues from the COVID-19 public health emergency, a request should be submitted to DHCS to negotiate an extension.

- **EQRO:** EQRO reviews will continue to be performed virtually until further notice. If a county cannot meet the scheduled timeline due to staffing issues from the COVID-19 public health emergency, a request should be submitted to the EQRO and DHCS for an extension to be negotiated.

- **Fiscal: DMC, DMC-ODS, MHSA, SMHS, SABG):** DHCS will continue performing reviews virtually to allow catch-up of fiscal audits. DHCS is working to streamline the current auditing process as per the Audit Plans in the tables below to accomplish this goal, audits cannot be delayed. If a county is unable to meet the requested document submission timeline, an extension request should be submitted to DHCS. Note: the impact of fiscal audit extensions will be ongoing delays in financial settlements.

DMC State Plan / DMC ODS / SABG Audit Plan

Fiscal Year Ended	Interim Settlement Date From Audit Plan	Months After Fiscal Year End	Audit Completion Date per Audit Plan	Months After Fiscal Year End
6/30/2016	6/30/2020	48	12/31/2020	54
6/30/2017	12/31/2020	30	6/30/2021	48
6/30/2018	7/31/2021	37	1/31/2022	43
6/30/2019	1/31/2022	31	7/31/2022	37
6/30/2020	7/31/2022	25	1/31/2023	31

SMHS / MHSA Audit Plan

Fiscal Year Ended	Interim Settlement Date From Audit Plan	Months After Fiscal Year End	Audit Completion Date per Audit Plan	Months After Fiscal Year End
6/30/2014	11/15/2020	77	6/30/2021	84
6/30/2015	1/15/2021	67	6/30/2021	72
6/30/2016	3/15/2021	57	9/30/2021	63
6/30/2017	5/15/2021	47	6/30/2022	60
6/30/2018	7/15/2021	31	6/30/2022	48
6/30/2019	9/15/2021	27	9/30/2022	39
6/30/2020	2/15/2022	20	1/31/2023	29

- **MHSA Program Reviews:** DHCS has temporarily suspended MHSA program onsite reviews. Due to restricted resources, it may not be feasible for a county to collect and submit the documents necessary to perform the desk review by the previously published schedule. Counties wishing to continue the review as

scheduled should notify the DHCS analyst to complete a virtual review. DHCS anticipates resuming comprehensive MHSA program onsite reviews when COVID-19 related travel and social distancing restrictions are lifted. The reviews will commence per the existing triennial schedule at that time. Counties scheduled for a 2020 review during the emergency period will be contacted by DHCS to determine next steps for completing MHSA program reviews.

If a county wants an extension on an appeal or corrective action plan timeline, the county should contact DHCS via the following email addresses depending on the issue and type of appeal:

System Review Appeals:
MCBHDMonitoring@dhcs.ca.gov
cc: Mayumi.Hata@dhcs.ca.gov

Clinical (Chart) Review Appeals:
MHSDAppeals@dhcs.ca.gov ,
cc: MCBHDMonitoring@dhcs.ca.gov and Martine.Carlton@dhcs.ca.gov

Corrective Action Plan:
MCBHDMonitoring@dhcs.ca.gov

Fiscal Audit:
Jim.Burkhardt@dhcs.ca.gov

MHSA Program Reviews:
MHSA@dhcs.ca.gov

11. Process to Request Fee Reductions or Waivers (4/9/20)

SB 601 went into effect on January 1, 2020. The new law, set forth in Gov. Code Section, 11009.5, authorizes the DHCS to establish a process to reduce or waive any fees required to obtain a license, renew or activate a license, or replace a physical license for display, when a business has been displaced, or experiences economic hardship as a result of an emergency.

DHCS Mental Health Rehabilitation Centers (MHRC), Psychiatric Health Facilities (PHF), Narcotic Treatment Programs (NTP), DUI programs, or substance use disorder (SUD) residential and outpatient facilities**,** that have a license or certification issued by LCD, may submit a written request to DHCS for a fee reduction or waiver:

- Identify whether the request is for a reduction or waiver of fee(s);
- Identify the type of fee requested to be reduced or waived (i.e., renewal application fee, relocation fee, etc.) and the specific fee amount being requested to pay if seeking a fee reduction;
- Describe how this reduction or waiver is specific to the COVID-19 emergency;

- Describe the economic hardship or displacement that occurred due to the emergency;
- Identify the provider type (MHRC, PHF, NTP, DUI, SUD Residential or Outpatient);
- Identify the provider number and legal entity name;
- Identify the program/facility name;
- Identify the facility physical address;
- Identify the facility mailing address; and
- Identify the Program Director and contact person.

See BHIN 20-015 MHRC and PHF for additional flexibilities granted to facilities during the emergency on the DHCS COVID-19 Response website.

12. Meetings, Gatherings and Events

DHCS recommends that counties and providers follow guidance by the California Department of Public Health and limit unnecessary meetings, gatherings and events, and convert all possible meetings into virtual (live video or telephone) events. Governor Newsom's Executive Order N-25-20 provides guidance that meetings required to follow Bagley-Keene standards may be done virtually.
For this reason, DHCS is reaching out to training and technical assistance contractors and will consider no-cost extensions for events cancelled due to COVID-19, and encourages counties to do the same. Contracts funded by SAMHSA must be obligated and expended by the end of the period of availability for each grant award.

DHCS continues to closely monitor this situation and will issue further reminders and guidance, as appropriate. For questions regarding this BHIN, please contact DHCS Medi-Cal Behavioral Health County and Provider Monitoring at CountySupport@dhcs.ca.gov or contact your assigned county liaison.

Sincerely,

Kelly Pfeifer, M.D.
Deputy Director
Behavioral Health

Enclosure: FAQs

DHCS COVID-19 Frequently Asked Questions: Behavioral Health

Updated July 23, 2020

Principles:
DHCS recognizes that COVID-19 presents a myriad of challenges. DHCS is working collaboratively with counties, plans, providers, and other stakeholders to ensure we continue to protect access to care and services, while also minimizing COVID-19 spread. See the regularly updated DHCS COVID-19 Response webpage for more details.

Intake & Assessments

1. **Can DHCS clarify that assessment and medical necessity and level of care may also be done by telephone for Drug Medi-Cal Organized Delivery System (DMC-ODS) counties?** (4/9/20)

   Yes. Beginning on March 1, 2020, and for the duration of the emergency, the initial assessment of the beneficiary may be performed by telephone by a medical director, a licensed physician, a licensed practitioner of the healing arts (LPHA), or a certified AOD counselor. Outside of and during the emergency, this initial assessment can also be performed either face-to-face or via telehealth (STC 132.e; IA Section III.B.3.iv). The medical director, licensed physician, or LPHA must then use the information gathered in that face-to-face or telehealth assessment to establish a substance use disorder (SUD) diagnosis, medical necessity, and level of care (LOC) placement.

2. **Can the consultation between an LPHA and counselor that is needed for level of care determinations also be done by telephone (and not strictly by video)?** (4/9/20)

   Yes, for DMC-ODS counties, if the initial assessment of the beneficiary is performed by a certified AOD counselor in compliance with the IA, then the medical director/licensed physician/LPHA must evaluate that assessment with the counselor to establish an SUD diagnosis, medical necessity, and a LOC placement. Nothing in the Standard Terms and Conditions (STCs) or Interagency Agreement (IA) prevents this consultation with the counselor from being conducted via telephone. Therefore, if the certified counselor completed the initial assessment of the beneficiary in compliance with IA Section III.B.3.iv, then the medical director/licensed physician/LPHA can review the assessment with the counselor through a face-to-face, telehealth, or telephone discussion when establishing the SUD diagnosis, medical necessity, and level of care assignment.

3. **Can a licensed mental health professional provide direction to a Therapeutic Foster Care (TFC) parent through telehealth rather than in person?** (5/20/20)

   Yes. Telehealth and telephone may be used by licensed mental health professionals to provide direction to TFC parents during the emergency.

4. **During the emergency, are DMC-ODS providers still required to discharge beneficiaries if there is a lapse in treatment for more than 30 days?** (5/20/20)

   Yes. DMC-ODS providers are required to discharge beneficiaries when there is a lapse in treatment for more than 30 days, although beneficiaries can be readmitted. Beneficiaries should be reassessed for readmission when ready to resume treatment. Note: the two non-continuous residential stay limit still applies in DMC-ODS (1115 Waiver, Standard Terms and Condition (STC) 138-Residential Treatment).

5. **Will counties be allowed to use telehealth and telephone to provide services after the emergency?** (5/20/20)

   Telehealth and telephone services are currently allowed for most Specialty Mental Health Services, independent of the emergency.

   Both telehealth and telephone services are currently allowed during the emergency for DMC-ODS, whether or not the county opted to provide telehealth services. After the emergency ends, DHCS will continue to recommend that counties opt to reimburse services by telehealth, but telehealth is optional in the current 1115 waiver. After the public health emergency ends, the only services that a DMC-ODS county may provide via telephone are those that are explicitly identified in the DMC-ODS STCs.

   DHCS is proposing a State Plan Amendment (SPA) to add telehealth for individual counseling in Drug Medi-Cal, as per Cal. Welf. & Inst. Code § 14132.731. It is anticipated that this SPA will be effective on July 1, 2020.

Operational Requirements

6. **Does the 12-client limit remain in place now that counseling services can be conducted via telehealth and telephone?** (Updated 5/20/20)

   Yes. The 12-client group size limit still applies for counseling services conducted via telehealth and telephone for both DMC and DMC-ODS counties; however, providers must obtain consent from all the participants and take the necessary privacy and security precautions, in compliance with HIPAA and 42 CFR Part 2.

7. Can Mental Health Specialists and staff who will not be licensed, but have AOD Certification, provide a billable telehealth assessment? (4/9/20)

An intern, trainee, or waivered licensed professional under the supervision of a Licensed Professional of the Healing Arts (LPHA) may perform specialty mental health assessments and subsequent services by telephone, telehealth, or in-person, under supervision of a licensed professional. See MHSUDS Information Notice 17-040 for details about scope of practice.

8. What flexibilities are in place for medications? (5/20/20)

Medi-Cal allows patients to fill up to 100 days of non-controlled medications. Narcotic treatment programs can receive exemptions to provide take-home medications for patients who are sick or quarantined. See COVID-19 FAQ: Narcotic Treatment Programs for more detail. Patients receiving buprenorphine products can currently receive 30-day supplies on Medi-Cal. DHCS encourages providers to consider prescribing naloxone for individuals who receive buprenorphine or methadone take-home medications to reduce the risk of overdose.

Utilization limits on quantity, frequency, and duration of medications may be waived by means of an approved Treatment Authorization Request (TAR) if there is a documented medical necessity to do so. See DHCS pharmacy guidance.

Some medications are anticipated to be in short supply due to supply-chain challenges. The FDA keeps a list of medications in short supply, including some medications for behavioral health conditions. DHCS recommends that providers prescribe 100-day supplies of all chronic medications, and patients may obtain early refills if 75% of the estimated duration of the supply dispensed has elapsed (other than certain medications with quantity/frequency limitations). Pharmacies are required to supply up to 72 hours of prescribed medications in an emergency and may provide the emergency supply without an approved TAR.
Medi-Cal allows for, and reimburses, mail order pharmacy providers enrolled as pharmacy providers in the Medi-Cal program.

9. Can controlled substances be prescribed over the phone? (4/23/20)

This is a federal, not state, issue. SAMHSA released guidance that an initial evaluation by telehealth or telephone is allowed for buprenorphine during the emergency. The DEA COVID-19 website addresses all other controlled substances, which include sedatives and stimulants, under telemedicine. Practitioners can start a new controlled medication prescription by telephone for a patient who is already under their care by telephone. However, if a patient is new to the provider, controlled medications cannot be provided by telephone (other than buprenorphine). For patients new to the provider, prescribing controlled medications can only be done by live video or telemedicine.

10. How can providers maintain services in the face of staff shortages?

DHCS anticipates that staff illness and quarantine may create challenges for provider organizations. DHCS encourages providers to do contingency planning to ensure that patients are able to access needed care. DHCS provides specific guidance in the COVID-19 Behavioral Health Information Notice 20-009.

11. How do counties access the American Society of Addiction Medicine (ASAM) training modules referenced in the Intergovernmental Agreement? (4/9/20)

All ASAM trainings funded by DHCS include the required modules. Counties may, however, purchase the modules from ASAM to facilitate provider training.

12. Will DHCS waive provider ratios for network adequacy during the emergency? (5/20/20)

No. At this time, DHCS is not waiving network adequacy provider ratio requirements for Mental Health Plan (MHP) Provider Networks. In light of the emergency, DHCS allowed an extension for Network Adequacy Certification submissions to April 20, 2020. The 2020 Federal Network Certification Requirements for County Mental Health Plans (MHPs) are in BHIN 20-012. This guidance also clarifies that DHCS has moved to annual reporting for counties not on corrective action plans.

13. During the emergency, can the MHP certification of Network Adequacy Data and Documentation Submission Form be signed electronically? (New 7/23/20)

Yes. The county MHP certification of Network Adequacy Data and Documentation Submission Form can be signed electronically.

14. Can counties modify the Notice of Adverse Benefit Determination (NOABD) and/or Notice of Appeal Resolution (NAR) templates to include the information specified in BHIN 20-011? (5/20/20)

Yes. Counties may temporarily modify the state-issued "NOABD Your Rights Attachment" enclosure and "NAR Your Rights Attachment" enclosure templates attached to MHSUDS IN 18-010E to inform beneficiaries of the additional 120 days allowed to request a State Hearing, thereby allowing beneficiaries a total of 240 days to request a hearing during the emergency. DHCS recommends using the following language to modify the "NOABD Your Rights Attachment" and "NAR Your Rights Attachment":

"You must ask for a State Hearing within 120 days from the date of the "Notice of Appeal Resolution" letter. During the COVID-19 public health emergency, the timeframe for asking for a State Hearing has been extended an extra 120 days. If you receive a "Notice of Appeal Resolution" letter from March 1, 2020, through the end of the public health emergency, you must ask for a State Hearing within 240 days from the date of the "Notice of Appeal Resolution" letter. You can ask for a

State Hearing by phone, electronically, or in writing. Please note that if a beneficiary wants to receive a continuation of benefits during the Plan's appeal process or the State Fair Hearing appeal process, the beneficiary will still need to file a request for the continuation of benefits within the 10 day timeframe."

Also, counties must enter the remaining language such as contact information and addresses.

15. **May counties waive seven-day assessment requirements and instead allow providers the DHCS requirement of a 30-day timeframe to complete the assessment?** (5/20/20)

Yes. Counties may set their own initial assessment timeframe as long as the timeframe is within the 30-day DHCS requirement.

16. **Can counties send documents to beneficiaries via email, such as grievance acknowledgment letters and responses, NOABDs, etc., as long as the beneficiary consents to the use of email?** (5/20/20)

Yes. When a beneficiary consents to the use of email communication, and that consent has been documented, counties may send SMHS, DMC-ODS, and DMC State Plan notices via email. However, the information must be provided to the beneficiary consistent with the content requirements set forth in the applicable 42 CFR Part 438 requirements, and in a manner consistent with the language and format requirements contained in 42 CFR §438.10. Counties must also ensure compliance with all applicable State and Federal privacy and security requirements when electronically transmitting personally identifiable information (PII) and protected health information (PHI) to beneficiaries.

17. **During the emergency, can the county waive a county requirement for a minimum number of hours of clinical services for residential treatment?** (5/20/20)

Yes. County-specific requirements can be waived as long as all DHCS requirements are met.

18. **During the emergency, are there any flexibilities for the DMC-ODS and State Plan Intensive Outpatient Treatment (IOT) and residential requirement that the therapist or counselor must record a minimum of 1 progress note per calendar week?** (New 7/23/20)

No. There are no flexibilities for the- progress note requirement. DMC-ODS counties must continue to comply with the progress note requirements per the Interagency Agreement (IA). Exhibit A. Attachment I.OO.14.i.a.i; and DMC State Plan counties must continue to comply with 22 CCR 51341.1(h)(3)(B).

19. During the emergency, will DHCS consider revising the timeline requirements for processing, issuing and logging grievances, appeals, and Notices of Adverse Benefit Determination (NOABDs)? (New 7/23/20)

No. There are no changes or flexibilities regarding the counties' responsibility for NOABD timelines. DHCS is not considering revisions to the NOABD timelines at this time. The exception granted was to extend the beneficiaries timelines to request grievances and appeals. As such, the exception is a temporary modification allowing beneficiaries an extra 120 days in addition to the standard 120 days to request a State Fair Hearing (for a total of 240 days). For more detailed information please see BHIN 20-011.

20. During the emergency, will DHCS revise the timeline requirement for requests for service (timely access)? (New 7/23/20)

No. DHCS is no longer pursuing this flexibility.

21. During the emergency, there have been provider reductions in staff and capacity. Do counties have to report provider changes to DHCS?(New 7/23/20)

Yes. MHSD IN 18-011, requires that plans notify DHCS, within 10 business days, any time there has been a significant change in the Plan's operations that would affect the adequacy and capacity of services, including but not limited to the composition of the plan's provider network. DHCS is requiring that these notifications continue. Counties may reach out to their DHCS liaison with concerns, as indicated in BHIN 20-009.

22. Can counties postpone updating the Provider Directory during the emergency? (New 7/23/20)

No. Counties cannot postpone updating the provider directory and must update their paper provider directory at least monthly and must update the electronic provider directory within 30 calendar days of receiving updated provider information in order for beneficiaries to know how to access services
(42 C.F.R. § 438.10 sub.(h)).

23. During the emergency, will there be any additional flexibilities for the DMC-ODS required hours for Intensive Outpatient Treatment (IOT)? (New 7/23/20)

No. The requirements for Intensive Outpatient Treatment services are described in the Intergovernmental Agreement for those counties participating in the DMC-ODS.

24. During the emergency, if a county that has opted into the DMC-ODS waiver has closed a facility or no longer accepts clients due to physical distancing, is the county required to offer the same type of modality at another site?
(New 7/23/20)

Yes. Counties must meet network adequacy standards, thus, if a DMC-ODS facility/provider location closed or limited its capacity to practice physical distancing,

the county must provide all medically necessary services at another location and/or via telephone and telehealth.

25. **Is it acceptable to use the place of service code 02 in a telehealth claim for DMC services and specialty mental health services?** (New 7/23/20)

Yes. The place of service code 02 (telehealth modifier) is acceptable for services that may be provided through telehealth for both DMC and SMHS services. For more details see the SMHS billing manual and BHIN 20-009 for DMC ODS.

26. **During the emergency, will there be flexibilities for the annual SUD Provider training referenced in Title 22 training which is required by the end of the fiscal year (June 30th).** (New 7/23/20)

No. There are no flexibilities for the required SUD provider training referenced in Tittle 22. Please note that the training can be provided via a virtual setting (e.g., webinar).

27. **Will the required Performance Improvement Projects (PIP) which are submitted through External Quality Review Organization (EQRO) be waived during the emergency?** (New 7/23/20)

No. PIP requirements have not been waived, counties should continue their PIPs in accordance with federal and contractual requirements. If counties are having trouble meeting PIP submission deadlines, or other PIP requirements, or if they needed help modifying their PIPs due to the emergency, they should reach out to Behavioral Health Concepts (BHC), Inc. for extensions, or for technical assistance.

28. **For individuals placed on a 5150 hold and in the ER, is it permissible for the professional person in charge of a Crisis Stabilization Unit (CSU) or their designee to conduct an assessment via telehealth prior to admission to the CSU, so that the professional person in charge or their designee can be counted as part of the required staffing ratio at the CSU?** (New 7/23/20)

No. The assessment is not allowable via telehealth and must be in-person pursuant to Welfare and Institutions (W&I) Code section 5151, “Prior to admitting a person to the facility for treatment and evaluation pursuant to Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention.”

29. **How can behavioral health providers obtain personal protective equipment (PPE)?** (New 7/23/20)

Resources on infection mitigation in behavioral health facilities are as follows:

- California Department of Public Health (CDPH) and DHCSD co-published Infection Mitigation in Behavioral Health Facilities

- ASAM's Infection Mitigation in Residential Treatment Facilities, which provides helpful information on the same, designed for SUD residential treatment.
- National Council on Behavioral Health COVID-19 guidance for behavioral health facilities

Ordering PPE:
The Medical Health Operational Area Coordination (MHOAC) is responsible for managing disaster medical resources, including personnel, equipment, and supplies. Resource management includes assessing disaster medical response needs, tracking available resources, and requesting or providing mutual aid. The status of local available resources within the OA is assessed before requesting outside resources or submitting a resource request to the Region Disaster Medical Health Coordination/Specialist Program (RDMHC/S). Following an assessment of local resources, the MHOAC may request or provide mutual aid as conditions warrant. The MHOAC acts as the single-point ordering authority for OA medical health mutual aid requirements. If necessary, the MHOAC may also request the public health and medical Department Operations Center (DOC) or OA Emergency Operations Center to be activated to support the public health or medical event.

If the MHOAC cannot fulfill a request using local sources, counties may request public health and medical resources from outside of the OA via the RDMHC/S. If regional resources are inadequate or delayed, the RDMHC Program will forward the request to the State. If in-State resources are unable to fill the request in a timely manner, the State will request Federal assistance through the California Office of Emergency Services (Cal OES). Acting through Cal OES, the Governor will request Strategic National Stockpile via the Department of Homeland Security. Please be aware that while every effort will be made to obtain resources as quickly as possible, requesting entities should anticipate that time from acceptance of a request to actual receipt of the resource may be 48-96 hours or longer, depending on the type and scope of the incident.

Please visit this link for the Medical Health Operational Coordinators for each county. And please see the Medical Health Operational Area Coordination (MHOAC) Manual for more information.

Additionally, The National Council for Behavioral Health is accepting orders for medical face masks. If you need medical face masks, they still have a limited supply available for purchase. These masks come in batches of 200 and are being sold "at cost," with shipping charges included.

Please visit this link to secure your order today.

If you have questions, you may contact The National Council via email at Orders@TheNationalCouncil.org.

Client Signatures, Documentation, Consents and Privacy

30. How should counties and providers manage signature requirements during the emergency? (5/20/20)

Client signatures are currently required in many situations: release of information, consent forms, notices of privacy practices, treatment plans, group visit sign-in sheets, admission agreements, and others).

If a signature can be obtained through a HIPAA-compliant app, such as DocuSign, that is permissible, if a Business Associate Agreement (BAA) is in place with the electronic signature vendor. Counties must ensure compliance with all applicable privacy laws, including HIPAA, 42 CFR Part 2, and the Information Practices Act (IPA), whenever they transfer PHI through a secure electronic signature platform.

If a signature cannot be obtained, for any reason, the reason for the missing signature should be documented in the client record. For SMHS, Section 1810.440(c)(2)(B) of Title 9 of the California Code of Regulations applies, which gives an exception to the signature requirement when the client is unavailable.

When the public health emergency ends, DHCS does not require counties and providers to "make up" missing or late signatures, and will not ask for collection of signatures for clients starting and/or ending treatment during the emergency. However, the requirement for signatures would resume, and signatures would need to be obtained when they are due, on a "go-forward" basis. Signatures should not be backdated. (For example, if an annual treatment plan was not signed during the emergency, but the client is receiving in-person services on a date when a new signature would be due, then the signature would be required when it is due).

Documentation of consent for telephone or telehealth services is not required. Executive Order N-43-20 states that the requirements specified in Business and Professions Code section 2290.5(b) related to the responsibility of a health care provider to obtain verbal or written consent before using telehealth to deliver services and to document that consent is suspended.

Executive Order N-55-20 waives the requirement for patient signatures for psychiatric medication consents. Instead, counties shall allow a patient's verbal consent (in lieu of written consent) for receiving psychiatric medication(s), due to the difficulty of collecting signatures when services are provided via telephone or telehealth.

31. May providers share SUD diagnosis information during this emergency? (4/9/20)

Yes. SAMHSA issued new guidance which allows providers to share patient SUD diagnosis information that would normally be protected under 42 CFR Part 2 in instances of a bona fide medical emergency. Usage of the medical emergency exception must be documented by providers.

32. Does DHCS have specific expectations for documentation of services delivered by telephone or telehealth? (4/9/20)

Counties should continue following current documentation requirements unless informed otherwise by DHCS. The IA (specifically, Exhibit A, Attachment I A2 15. "Progress Notes") specifies the documentation requirements in the DMC-ODS.

33. Will the telehealth Health Insurance Portability and Accountability Act (HIPAA) flexibilities be expanded to include 42 CFR Part 2 requirements? (New 7/23/20)

No. DHCS did not request any flexibilities for 42 CFR Part 2, which addresses the confidentiality of substance use disorder records.

34. What SMHS can be provided to a beneficiary before his or her client plan is approved? (New 7/23/20)

Prior to the client plan being approved, the following SMHS and service activities are reimbursable:

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization
- Medication Support Services (for assessment, evaluation, or plan development; **or *if there is an urgent need***, *which must be documented*)
- Targeted Case Management and Intensive Care Coordination (ICC) (for plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services.

35. When is a beneficiary's signature required on a client plan? (New 7/23/20)

The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:

- The beneficiary is expected to be in long-term treatment as determined by the MHP; and, the client plan provides that the beneficiary will be receiving more than one type of SMHS; and/or
- The MHP documentation standards require it.

When a beneficiary's signature or the signature of the legal representative is required, but the beneficiary refuses to sign the client plan or is unavailable, the MHP shall ensure the client plan includes a written explanation of the refusal or unavailability (MHP Contract; Cal. Code Regs. tit. 9, § 1810.440(c)(2)).

Data Reporting

36. Can DHCS clarify current expectation for the various county data reporting requirements? (4/9/20)

Reporting requirements during the COVID-19 public health emergency are as follows:

- Consumer Perception Survey - The next scheduled survey period is May 2020. Due to the COVID-19 emergency, DHCS has rescheduled the survey collection period to June 22-26, 2020.

- Client and Services Information System (CSI), Data Collection and Reporting System (DCR), California Outcomes Management System (CalOMS), and American Society of Addiction Medicine (ASAM) Level of Care - DHCS recognizes that there may be delays in submitting data. However, due to federal reporting requirements, DHCS is not able to waive data reporting requirements for CSI, DCR, CalOMS, and ASAM Level of Care Data.

- Child and Adolescent Needs and Strengths (CANS) & Pediatric Symptoms Checklist – 35 (PSC 35) - During this time of COVID-19, DHCS recognizes that there may be limitations in staff time as some staff are being redirected due to the emergency. As such, the CANS should be completed in partnership with placing agencies via telehealth or telephone. Furthermore, although IN 20-003 requires counties to include the CIN number with CANS and PSC-35 submissions to the FAST system, due to COVID-19, DHCS will extend the implementation of the mandatory CIN requirement to July 1, 2020.

Provider Enrollment

37. Can DHCS issue written clarification explaining whether and how the Provider Enrollment Division (PED) emergency bulletin, which outlines an expedited emergency enrollment process for Medi-Cal FFS providers, applies to DMC providers with pending applications for DMC site certification? Can providers with pending DMC certifications begin claiming for DMC/DMC-ODS services if they follow the procedure in the bulletin for FFS providers? If so, how does this impact the status of their existing DMC application? Are there specific steps they'd need to take after the emergency enrollment period passes)? (4/9/20)

DMC providers with DMC applications currently under review with PED can additionally apply for emergency enrollment pursuant to the Guidance for Emergency Medi-Cal Provider Enrollment. Their pending non-emergency enrollment DMC applications will not be impacted. Moreover, providers enrolled pursuant to the provider bulletin will be automatically deactivated at a later date based on the duration of the emergency. If a provider would like to continue their enrollment as a

DMC provider, they will need to submit a completed DMC provider application. If a provider currently has a pending non-emergency DMC application, it will continue to be reviewed in the order it was received, separately from any DMC application received pursuant to the emergency provider bulletin.

38. Will PED's Guidance for Emergency Medi-Cal Provider Enrollment apply to Specialty Mental Health? (4/9/20)

Pursuant to section 1135 of the Social Security Act (1135 Waiver) CMS has waived the enrollment requirement for SMHS providers to undergo an onsite visits per CFR, title 42, section 455.432(a). Moreover, part of the enrollment process for SMHS providers includes the requirement for the provider to obtain a fire clearance prior to the onsite visit, as specified in the county Mental Health Plan (MHP) contract. As stated under the MHP contract, Exhibit E, page 12 of 16, Paragraph 7(B), DHCS may use policy letters to provide clarification and instructions to its contactors regarding implementation of mandated obligations pursuant to State and federal statutes and regulations.

In light of the many challenges counties are facing due to the COVID-19 crisis, including the inability to obtain a fire clearance, DHCS is waiving the Medi-Cal Certification requirements for an onsite review and a fire clearance, during the approved 1135 Waiver period. During this time, providers may be certified using the streamlined procedures. See Behavioral Health IN 20-009 for more details.

39. Counties and providers have asked about fingerprinting requirements and noted that they can't do fingerprinting right now as facilities are closed. Is fingerprinting part of the provider enrollment background check process that can be waived? Is it also something that DHCS monitors outside of provider enrollment? If so, can DHCS clarify the expectation for providers who are still trying to obtain fingerprints from staff? (4/9/20)

As the provider bulletin states, providers who enroll using this method will not be subject to the following requirements: submission of an application fee, designation of screening levels, and submission of a completed Medi-Cal Provider e-Form Application, which includes a completed Medi-Cal Disclosure Information Section and Medi-Cal Provider Agreement. This includes application requirements such as fingerprints required for providers with moderate or high risk designations. However, this only applies to emergency enrollment pursuant to the provider bulletin. If a provider seeks regular enrollment in Medi-Cal, they are subject to the existing statutory and regulatory requirements for their provider type.

The requirements of Welfare and Institutions Code §5405 that individuals employed in MHRCs and PHFs undergo criminal background checks, including fingerprinting, remain in effect; however, DHCS may grant program flexibility when a provider proposes to use alternate concepts to comply with existing MHRC and PHF staffing regulations. Facilities requesting program flexibility should describe the alternate concepts needed to meet the intent of the above requirement and submit it to MHLC@dhcs.ca.gov for consideration.

Additionally, to facilitate processing of CBC clearances during the COVID-19 pandemic, DHCS has instituted the following:

- DHCS Mental Health Licensing Section will work collaboratively with facilities to process a Criminal Record Approval Transfer Notification (CRATN). An additional criminal background check (CBC) is not required if an individual or licensee has received a prior CBC clearance while working in a licensed facility and wishes to transfer to another similar facility. The individual or licensee who wishes to obtain a CRATN shall complete the DHCS Form 1818.

- An online criminal background check may be considered with the submission of DHCS Form 3007 and DHCS Form 3085.

- Once the DHCS Form 1818 has been submitted to DHCS, the individual with a DHCS-issued CBC clearance is allowed to start working in a PHF or MHRC.

- As was the case before the COVID-19 crisis, a new employee who has submitted fingerprint images/live scans can start working in a PHF or a MHRC while awaiting the CBC clearance as long as the employee is under constant supervision.

- If the individual will solely be providing services through telehealth, and will have no direct contact with the patient, then a criminal background check will not be required.

Licensing and Certification

40. Can DHCS waive the requirement that SUD treatment programs maintain a minimum of 30% licensed staff? (4/9/20)

DHCS does not require AOD treatment programs to maintain a minimum of 30% of licensed staff. Pursuant to California Code of Regulations Title 9 Chapter 8 Section 13010, at least 30% of staff providing counseling services in all AOD programs shall be licensed or certified.

41. Can individual providers receive a waiver to operate above their licensed capacity? (4/9/20)

To address the issue of insufficient AOD SUD treatment bed capacity, the Licensing & Certification Division will expedite review and approvals of requests for increases in treatment bed capacity. Residential SUD treatment facilities seeking to increase treatment bed capacity shall electronically submit a Supplemental Application (DHCS 5255) along with a Facility Staffing Data form (DHCS 5050) for review to LCDQuestions@dhcs.ca.gov. DHCS shall also review and approve facility

requests to temporarily operate above their licensed treatment bed capacity as long as the total bed capacity does not exceed the capacity allowed in the approved facility fire clearance.
For any specific operational flexibilities, including the need to operate above the licensed capacity for MHRCs and PHFs, requests may be made by email to: MHLC@dhcs.ca.gov. The request shall include the following written components:

- Description of alternate concepts, methods, procedures, techniques, equipment, and personnel qualifications.
- The reasons for the program flexibility request and justification that the goal or purpose of the regulations would be satisfied.
- The time period for which the program flexibility is requested.
- Policies and Procedures to implement the provisions of the program flexibility which demonstrate that this flexibility meets or exceeds provisions for patient care and safety.

42. What are the licensure requirements to allow SUD residential programs to relocate into new locations on an emergency basis? (4/9/20)

In accordance with California Code of Regulations Title 9 Chapter 5 Section 10527(c), facilities that move operations to new locations shall submit a Supplemental Application (DHCS 5255) within 60 days from the date of the move.

43. Are facilities able to provide treatment or recovery services outside the facility service location if there are concerns about providing treatment at the location due to COVID-19? (4/9/20)

In some circumstances, DHCS shall consider and may allow facilities to provide treatment or recovery services off-site for any concerns related to COVID-19.
Providers should contact their Licensing Analyst for questions. See COVID-19 Response website for information notices for treatment facilities.

44. Is DHCS waiving the 23-hour maximum length of stay in a Crisis Stabilization Unit (CSU) during the emergency? (5/20/20)

No. DHCS is not waiving the maximum length of stay requirement in a CSU, specified in California Code of Regulations, Title 9, Section 1810.210. However, in cases where a beneficiary remains in a CSU for more than 23 hours, the provider must be able to present evidence upon request by DHCS of good faith efforts they have made to transition the beneficiary out of the CSU to their residence or to an appropriate placement, including the reason(s) why that has not been possible.

45. Are psychiatric health facilities (PHF) and CSUs allowed to offer services outside of the licensed part of the facility at locations that are already Medi-Cal certified for outpatient services? (5/20/20)

DHCS will review requests regarding PHF licensing on a case-by-case basis (LCDQuestions@dhcs.ca.gov). For Medi-Cal Certification related questions, including those pertaining to CSUs, DHCS will review requests on a case-by-case basis (DMHCertification@dhcs.ca.gov).

46. DHCS requests proof that there is a psychiatrist and licensed person (LCSW, LMFT) on the PHF unit each day, which is later audited for the hours of attendance. May psychiatrists be available by telehealth, off-site? And can this obligation be addressed by having two licensed staff at a time? (5/20/20)

DHCS will review requests regarding PHF licensing requirements on a case-by-case basis (LCDQuestions@dhcs.ca.gov).

47. During the emergency, is it possible for DMC-ODS to use non-registered or non-certified staff with lived experience working under the supervision of licensed and/or certified staff to provide services in Recovery Support and Case Management? (5/20/20)

The current requirements for providing Recovery Support and Case Management services have not changed during the public health emergency. In DMC-ODS, non-registered and non-certified peers are allowed to provide Recovery Support services within their scope of practice, so long as the services are provided for within the context of the beneficiary's treatment plan, and the peer support worker meets the training and county designation requirements as specified in the DHCS-approved county SUD peer support training plan. However, counties must have a DHCS-approved county SUD peer support training plan in order to receive reimbursement for providing services by a peer. Non-registered or non-certified staff with lived experience are not allowed to provide Case Management services in DMC-ODS. Case Management services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor. For more information, please reference the DMC-ODS 1115 Waiver, Standard Terms and Condition (STC) 142 - Recovery Support Services and STC 143 - Case Management, as well as the Information Notice on peer support services: MHSUDS IN 17-008.

48. During the emergency, may Alcohol or Other Drug (AOD) counselors to provide services after their certification expires, while waiting for the renewal? (5/20/20)

As outlined in MHSUDS IN 18-056, if an AOD counselor fails to submit a renewal application prior to the expiration of their certification, the counselor may not provide counseling services until their certification is renewed. But, if an AOD counselor submits a renewal application prior to the expiration of their license, the counselor may continue to provide counseling services unless the certifying organization denies the renewal application.

If an AOD counselor submits an application for certification renewal before the expiration of their certification and if the renewal is approved, the expiration date for the renewed certification shall be two years from the expiration date of the prior certification. If the counselor's certification is denied, any service provided after the expiration date of the counselor's certification shall not be reimbursed with State or federal funds.

49. **The Director of the California Department of Consumer Affairs has temporarily waived some legal requirements for certain individuals seeking to renew a license or registration pursuant to Division 2 of the Business and Professions Code, including suspending some exam and continuing education requirements. Has DHCS issued any guidance for providers who hold a license or registration issued by the Board of Behavioral Sciences (BBS) that is set to expire?** (New 7/23/20)

No. BBS, however, has issued FAQs on this issue. These FAQs can be found here.

Licensees/registrants have until September 30, 2020, to take and pass any required exams and/or to complete any continuing education requirements. DHCS will consider an individual's license/registration valid during the extension such that the individual can continue to engage in the full scope of practice as allowable by law.

50. **During the emergency, and in light of training cancellations, can staff whose "5150" certification is expired still be allowed to conduct 5150 holds?** (New 7/23/20)

Per W&I code 5121, the county behavioral health director has authority to develop requirements and processes to designate who can perform functions under W&I 5150, including the process for monitoring and reviewing professionals that have been designated. Therefore, this is a decision for counties to make.

51. **Can MHPs and DMC-ODS Counties rely on provider credentialing performed by a subcontractor or credentialing agency to comply with the provider credentialing requirements contained in MHSUDS IN 18-019?** (New 7/23/20)

MHPs and DMC-ODS Counties may decide whether or not to accept credentialing performed by a subcontractor or other agency. However, if an MHP/DMC-ODS County makes the decision to rely on a subcontractor or other agency's credentialing, it is ultimately responsible for verifying that the provider is credentialed in accordance with MHSUDS IN 18-019 wherein it states that:

"Provider Credentialing and Re-credentialing Procedures:
A Plan may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the Plan remains contractually responsible for the completeness and accuracy of these activities. If the Plan delegates credential verification activities to a subcontractor, it shall establish a formal and detailed agreement with the entity performing those

activities. To ensure accountability for these activities, the Plan must establish a system that:

- Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensures that the subcontractor meets the Plan's and DHCS' standards; and
- Continuously monitors, evaluates, and approves the delegated functions.

Plans are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contract requirements as well as DHCS guidance, including applicable INs."

Authorizations (Section Added on 5/20/20)

52. Can counties process TARs electronically through a secure system like DocuSign that would allow for an electronic signature? (5/20/20)

Yes. Counties can process TARs electronically through acceptable HIPAA-compliant secure electronic signature platform such as DocuSign. The digital signature must meet requirements under California Government Code 16.5 and California Secretary of State Regulations for Digital Signatures. Counties must ensure compliance with all applicable privacy laws, including HIPAA, 42 CFR Part 2, and the IPA, whenever they submit a TAR to DHCS and, generally, whenever they transfer PHI through an electronic signature platform. As such, counties must have a BAA in place with the electronic signature vendor when using an electronic signature platform for TAR submission.

53. Is DHCS allowing hospitals to transmit TARs via eFax rather than mail? (5/20/20)

Yes. DHCS does not require a specific medium for TARs; however, counties must be compliant with HIPAA and all applicable State and Federal privacy requirements when electronically transmitting PHI.

54. The March 23, 2020, 1135 waiver approval temporarily suspends prior authorization requirements for benefits delivered through the fee-for-service delivery system. Will Mental Health Plan (MHP) authorization activities be waived during this time (Crisis Residential, etc.)? (5/20/20)

No. At this time authorization requirements are not waived. The Department requested clarification from CMS in its March 16, 2020, letter, but at this time, the suspension of prior authorization requirements in fee-for-service does not apply to Mental Health Plans.

55. Can the County of Responsibility deny transfers to non-contracted hospitals from EDs for 5150 holds? (5/20/20)

No. The County of Responsibility may not deny this emergency admission to a psychiatric inpatient hospital, as per Information Notice 19-026, which states that "upon notification by a hospital, MHPs shall authorize payment for out-of-network services when a beneficiary of the MHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services." The County of Responsibility may propose an alternative placement with a county-contracted psychiatric inpatient hospital, which the ED staff may consider.

Behavioral Health Finance (New Section 5/20/20)

56. Do counties have to get state approval to change the rates for services such as crisis residential or transitional residential treatment or day rehab? (5/20/20)

No. Counties have the authority within the cost-based reimbursement structure to change their rates to contract providers without DHCS approval. DHCS is working with CMS to obtain waiver authority to provide more payment flexibility. Detailed information is available in BHIN 20-024.

57. Will the state offer resources for providers to purchase phones or equipment for clients? (5/20/20)

DHCS understands the need; unfortunately, each funding source has limitations.

- MHSA funding could be used to provide phones for clients in Full Service Partnerships.
- SAMHSA block grant funding can be used for staff provider phones and telehealth equipment for discretionary grants, but not for participant phones or telehealth equipment.
- DMC, DMC-ODS, and SMHS funding cannot be used to pay for phones for participants.
- The Lifeline program is available and can provide free phones and discounted services plans.

58. How do providers access federal grant opportunities? (5/20/20)

Providers should stay updated by regularly checking the federal websites for grant opportunities. DHCS has a web page that reflects a compilation of websites that may be followed to search for grant funding opportunities. These links can provide more information on the following opportunities:

- provider relief fund
- grants.gov
- telehealth
- small business loans

SAMHSA grant announcements are on this webpage, and you can sign up for email alerts.

The Small Business Administration recently issued two interim final rules to supplement previously posted interim final rules on the Paycheck Protection Program (PPP) with additional guidance regarding disbursements, as well as guidance on the amount of PPP loans that any single corporate group may receive and criteria for non-bank lender participation in the PPP.

59. Information notice 18-012 notes that updates to Information Technology systems in order to comply with Final Rule requirements may be reimbursable as a final rule claim. Would purchasing additional technology and software upgrades to continue to meet Network Adequacy Requirements during the COVID-19 situation be a claimable final rule expenditure? (New 7/23/20)

No. While DHCS is encouraging the use of telehealth during the COVID-19 public health emergency, it is not imposing a new requirement on the counties to provide SMH and DMC services via telehealth; therefore, no additional funding is available for IT costs associated with implementing telehealth. Counties are mandated to ensure timely access to medically necessary SMH and DMC services. Accordingly, counties may choose to do so via telehealth using appropriate, existing funding resources to pay for it.

SAMHSA Block Grants

60. Are Counties permitted to use Substance Abuse Prevention and Treatment Block Grant (SABG) funds for for-profit Recovery Residence (RR) providers? (5/20/20)

Yes. The SABG funds are allowable for for-profit RR providers if the county is providing the service as described in MHSUDS IN 18-058 and in accordance with the SABG implementing regulations. For additional clarification and other SABG questions, please email SABGpolicymanualcomments@dhcs.ca.gov.

61. Can DHCS allow the county to bill Medi-Cal and receive payment for ongoing SUD services, even if a residential level of care is not medically necessary or the client has hit the maximum length of stay permitted by DMC-ODS, until such time that an appropriate discharge plan can be put in place for recovery residence, shelter, or other safe housing and the provider documents efforts to transition client to an outpatient level of care? (5/20/20)

No. Counties cannot bill Drug Medi-Cal or DMC-ODS when extending treatment due to the public health emergency if no medical necessity for treatment exists. Counties can use SABG funds as described above. For additional SABG questions please submit to: SABGpolicymanualcomments@dhcs.ca.gov.

62. What are the original statutory Maintenance of Effort (MOE) levels for counties? (5/20/20)

There is no federal or state statutory MOE requirement for counties. The MOE is an aggregate state expenditure requirement for the "principle agency," which is defined by SAMHSA as the "Single State Agency." The California Health and Safety Code (HSC), Section 11754 designates the DHCS as the single state agency authorized to receive block grant funds.
The SABG MOE requirement is contained in Title 42, United States Code (USC), Section 300x-30, and Title 45 Code of Federal Regulations (CFR), Part 96, Section 96.134(a). Per 42 USC, Section 300x-30(a) and 45 CFR Section 96.134(a), DHCS, as the principle agency for carrying out authorized substance use disorder (SUD) prevention and treatment activities, is required for each fiscal year to maintain aggregate state expenditures for such activities at a level that is not less than the average level of such expenditures for the two-year period preceding the fiscal year for which the State is applying for the grant. For example, DHCS, in submitting its federal fiscal (FFY) 2020 SABG Report, was required to report its aggregate state expenditures for state fiscal year (SFY) 2019. The SFY 2019 expenditures must equal or exceed the average state expenditures reported for SFYs 2017, and 2018.

Community Mental Health Services Block Grant (MHBG)
Title 42 USC Chapter 6A, Subchapter XVII, Part B, §300x-4 (b)(l) requires the state to maintain expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the two-year period preceding the fiscal year for which the state is applying for the grant. However, for the MHBG, the MOE can include all state expenditure for authorized services/activities.

Any questions regarding MOE requirements should be addressed to Erica Talbert, Program Analyst, DSCSD, CMHS; Erica.Talbert@samhsa.hhs.gov .

The DHCS, SABG and MHBG contacts are as follows:

SABG

- SABG@dhcs.ca.gov (SABG applications & general questions)
  SABGReporting@dhcs.ca.gov (SABG financials, data submission, or invoicing issues)
- SABGpolicymanualcomments@dhcs.ca.gov (SABG policy questions)

MHBG

- MHBG@dhcs.ca.gov (MHBG applications & general questions)
- MHBGReporting@dhcs.ca.gov (MHBG financials, data submission, or invoicing issues)

63. Will the MOE requirement be relaxed or suspended during the emergency? (5/20/20)

According to SAMHSA, the U.S. Department of Health and Human Services (HHS) Secretary (Secretary) may, upon the request of a State, waive the MOE requirement in whole or in part if the Secretary determines that extraordinary economic conditions in the State in the fiscal year involved or in the previous fiscal year justify the waiver.

Please Note: MOE Waivers cannot be requested for anticipated MOE deficiencies in future SFYs. Any SABG/MHBG MOE waiver would need to be submitted after the annual FFY SABG or MHBG Report is submitted on December 1, 2020, as appropriate after the annual MOE is calculated.

General COVID-19 Information

64. Where are up-to-date resources on COVID-19?

California Department of Public Health – COVID-19 Updates
CDPH Gathering/Meeting Guidance
CDC COVID-19 webpage
Guidance for the Elderly
Guidance for Employers
What to do if you are sick
Guidance for Workplace/School/Home Document
Steps to Prevent Illness
Guidance for use of Certain Industrial Respirators by Health Care Personnel
Medicaid.gov, COVID-19 resource page
CMS: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications
Governor Newsom's 3/12/20 Order
CDPH: For Individuals With Access and Functional Needs

65. How should behavioral health programs reduce transmission of COVID-19?
The CDC has provided interim infection prevention and control recommendations in health care settings. Recommendations include:

- Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.
- Wash hands often with soap and water for at least 20 seconds.
- Cover mouth and nose with a tissue when coughing or sneezing and immediately dispose of the tissue.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Clean all surfaces and knobs several times each day with sanitizers.
- Anyone with a respiratory illness (e.g., cough, runny nose) should be given a mask before entering the space.
- Stay home and away from others when sick.

66. How should behavioral health providers manage patients presenting with upper respiratory symptoms? (Updated 5/20/20)

DHCS strongly encourages use of telehealth or telephone services to minimize infection spread.

When telehealth is not available, providers should develop procedures to minimize the risk that symptomatic patients will infect staff or other patients. Patients with cough should wear a mask if available.

Programs should follow infection prevention and control recommendations in health care settings published by the CDC (please see #35 below for more details).

67. When should programs refer a patient to medical care?

There is currently no treatment for COVID-19, only supportive care for severe illness. Mildly symptomatic patients should stay home. See CDC guidelines for health care professionals on when patients with suspected COVID-19 should seek medical care.

68. What should SUD facilities do in the event a client is diagnosed with COVID-19?

If a client of an outpatient facility is confirmed to be positive for COVID-19, the client should be instructed to stay home. Services may be provided by telephone or telehealth (see question 8). Residential or inpatient facilities with a patient or resident diagnosed with COVID-19 should ensure the patient is isolated in a room, has a mask for use when leaving the room, and should contact their local public health department for guidance. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID-19.

69. If a former client is later found to have been diagnosed with COVID-19, what action should be taken?

Staff should inform possible contacts of their possible exposure, but must protect and maintain the participant's confidentiality as required by law. Clients exposed to a person with confirmed COVID-19 should refer to CDC guidance on how to address their potential exposure, as recommendations are evolving over time.

70. What should SUD facilities do in the event a staff member is diagnosed with COVID-19?

Staff members who have symptoms of a respiratory illness should stay home until symptoms completely resolve. Staff members with confirmed COVID-19 infection, or who are under investigation (testing pending), should stay home and the facility should contact their local public health department for guidance. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID-19.

71. What else can behavioral health programs do to prepare for or respond to COVID-19?

DHCS encourages providers to adhere to the CDC's and CDPH's recommendations to prepare for COVID-19. Some helpful preparedness strategies include but are not limited to the following:

- **Screen patients and visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering your healthcare facility. Providers can refer to the following resources on the CDC's Guidelines for patient screening and Infection Prevention and Control Recommendations for more information.**
- **Ensure proper use of personal protection equipment (PPE)** Healthcare personnel who come in close contact with confirmed or possible patients with COVID-19 should wear the appropriate personal protective equipment.
- **Encourage sick employees to stay home** Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.
- **Encourage adherence to the CDC's** recommendations, including but not limited to the following steps, to prevent the spread of illness:
    - Avoid close contact with people who are sick.
    - Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
    - Avoid touching your eyes, nose, and mouth.
    - Clean and disinfect frequently touched objects and surfaces.
    - Stay home when you are sick, except to get medical care.
    - Wash your hands often with soap and water for at least 20 seconds.
- **Ensure up-to-date emergency contacts** for employees and patients.
- **Reach out to patients** through phone calls, emails, and onsite signs to contact the treatment program before coming onsite if they develop symptoms, so alternatives (such as telephone or telehealth visits) can be discussed.
- **Change seating in waiting room and group visit sessions** to maintain a six- foot distance between patients.
- **Limit group visits,** especially for those at high risk (e.g., over age 60). If you hold group visits, set up chairs six feet apart.
- **Protect the health of high-risk staff**. For example, staff over the age of 60 or with health conditions should consider conducting all or most visits by telephone and telehealth visits, where appropriate.