Maryland
DEPARTMENT OF HEALTH

Frequently Asked Questions:
Coronavirus Disease 2019 (COVID-19) and Behavioral Health Administration Partners

Updated April 23, 2020

The Maryland Department of Health (MDH) Behavioral Health Administration (BHA) continues to develop coordinated prevention and response plans for COVID-19. BHA will provide COVID-19 updates as they become available and accurate information for behavioral health providers, partners, and the greater community. For the latest COVID-19 information and resources, visit the BHA website or coronavirus.maryland.gov. If you have a behavioral health question related to COVID-19 that has not been addressed, please submit it here. For additional questions or concerns, contact your Local Behavioral Health Authority.

NEW Are there any tools available that providers can download to use for screening new admissions?

The Grassroots Crisis Stabilization Center is sharing their COVID-19 screening tool used for those entering into their facility for crisis support services (non-residential). The Grassroots COVID-19 Screening Tool is based on CDC information. Please note: (1) that an individual with a score under 5 after screened with their tool could still have COVID-19 but may only have mild symptoms or be asymptomatic and (2) The CDC recommends that a cloth face covering should be worn in community settings, especially in situations where one may be near others, for example at the grocery store, pharmacy, or healthcare appointment.

NEW What actions can behavioral health providers take to provide a safe environment for staff?

The Maryland Treatment Centers took action in response to staff shortages and the need to implement safer admission procedures to reduce the risk of coronavirus transmission in a substance use disorder residential setting. Their actions are summarized here. For further information please send an email to mfishman@marylandtreatment.org.

NEW There was a question posted previously about residential SUD programs having increased difficulties meeting the COMAR requirements for service hours across the various levels of care. Is there any further guidance on this?

The most recent telehealth guidance for residential treatment programs has additional information on service hours.

NEW Medicare has more stringent requirements than Medicaid. Will their requirement to have a prescriber on site to bill to unless an LCSW-C is the provider continue in light of the changes in response to COVID-19? Given that our prescribers aren't really on-site as well right now, our Medicare clients have somewhat been impacted. We are still providing care as needed per Medicare clients' needs because it's the right thing to do, however we haven't been able to bill. Is there any flexibility with Medicaid at this time?

MDH is not able to provide guidance regarding the interpretation of Medicare rules.

For Residential Rehabilitation Programs, should the stimulus checks on the entitlement forms be noted in the unearned income section?

No. The Social Security Administration (SSA) and Family Investment Administration (FIA) are disregarding the $1,200 Economic Impact Payment also known as 'stimulus payment' as income for all benefit programs. This means Economic Impact Payments are not counted as income for any Social Security or means-tested benefit program (including SSI, SNAP, PAA, Medicaid, TCA, and TDAP). Therefore, RRPs should NOT include the $1,200 Economic Impact Payment within the unearned income section of the entitlement form. Instead, these payments should be used to assist an individual in their goals during this time period.

Remember that SSI and Medicaid programs enforce a $2,000 resource limit. If Economic Impact Payments will be placed into savings for an individual, please be aware that it will NOT impact benefit eligibility for 12 months, however, individuals may lose SSI and/or Medicaid benefits if their resources (other than assets within a Special Needs Trust or ABLE account) total more than $2,000 after that 12 month period.

Please note, stimulus payments should not be confused with the $600 weekly benefit recently made available to recipients of Unemployment Insurance (UI) benefits through the Pandemic Unemployment Compensation (PUC) program. UI benefits, including this additional weekly $600 PUC benefit, IS counted as unearned income for SSI purposes and should be included as such within RRP entitlement forms.

We have been allowed to bill the blended PRP billing rate because we have both an onsite facility and offsite services, even for those individuals who did not have an onsite visit in a particular month. Now that onsite PRPs are closed due to distancing and crowd-size restrictions, can we still bill the blended rate for our PRP clients?

Yes, provided that the program otherwise meets the minimum threshold for encounters for the blended PRP rate. However, given the heightened risk of social isolation among PRP service recipients secondary, in part, to the discontinuation of onsite PRP services, PRP programs are expected to mitigate this risk by providing continued, frequent contact with service recipients via telehealth and telephone. If PRP group services of longer duration are not feasible, such services should be replaced with more frequent individualized PRP contacts of shorter duration. It should be presumed that, during this time of reduced social contact and social distancing, most service recipients will have significantly more PRP service and support needs than can be reasonably accommodated by PRP services that merely meet established minimum standards for reimbursement.

Some of our PRP clients see an external (not affiliated with our organization) clinician/OMHC that is no longer providing services-at least for now. Can you waive the six-month Verification of Diagnosis/clinical authorization for these individuals so they can continue to receive PRP services?

This requirement is not waived. BHA expects that PRP service recipients remain engaged in outpatient mental health treatment, given that, pursuant to guidance issued by MDH on March 21, 2020, outpatient behavioral health treatment may be delivered by various telehealth modalities.

Are PRP intakes allowed via telephone (audio only)?

Yes, but only if no telehealth (video) based alternatives are available and with the participant's informed consent.

For PRP services, is there a requirement of a BAA to be in place for all group activities that will count as an onsite? And does it have to be via a HIPAA compliant platform for it to be considered an onsite?

A Business Agreement (BAA) is normally required for all telehealth services, but the Department of Health and Human Services has waived enforcement of this during the state of emergency, along with the requirement for a HIPAA compliant platform. However, only non-public facing telehealth video applications are permitted, and public facing services such as Facebook Live, Snapchat, etc. are not permitted. While a Business Agreement is strongly preferred, it is not required during the emergency.

If a client declines recording the PRP session, should we discontinue service?

There is no requirement that a PRP session be recorded. It must be documented, however, in compliance with existing regulatory standards. Additionally, if done by telephone there must be clear evidence that the consumer provided informed consent and billing/data records of the call must be maintained. If the consumer declines the service itself, then the service should be discontinued, although further clinical interventions may be justified by the situation.

Are verbal consents for release of information currently acceptable? Will signatures for intakes/assessments etc. be required after COVID-19 for any documents where verbal consent was given? How should we go about obtaining releases of information to speak to outside agencies, etc. about patient information?

Staff should make a good faith effort to secure some form of signed consent. The following options are available:

1. Email or mail the consent to an individual for him or her to sign and return. This can also include using a program like DocuSign so the individual can sign electronically. If the individual does not have the ability to print the document, the individual can electronically sign the consent with a signature and their name and email it back.
2. Have employees sign up for a Google Voice account that they can use to text consumers from their computers. They can then text a copy of the consent to the consumers, who can download it as well as the free Adobe Fill and Sign app to sign the consent with their phone, or who can use their phone's built in photo editing tool to sign the document.
3. If the individual does not have email access or a smartphone to be able to access a form to sign, then in those limited situations, after reading the release over the phone and documenting that the release was read and verbally consented to, a verbal release will be accepted in these limited circumstances, since it is consistent with the Governor's executive order aimed at reducing congregating in public waiting rooms. It should be followed up with an attempt to mail a written consent form for the individual to sign as soon as possible.

How important is it for providers to keep authorizations and claims up to date while the system is operating under the Estimated Payment system, and Optum’s Incedo Provider Portal (IPP) is not yet "activated"?

Keeping claims and authorizations up to date is critical for three reasons:

1. Providers will have fewer claims and authorizations to enter when the system is reactivated, lessening the load on your staff to enter the information.
2. Reconciling estimated payments to backlogged submitted claims will be more accurate.
3. Testing and implementing system fixes will be more effective with more claims and authorizations entered in the system, ensuring that the IPP is working properly before being reactivated.

For PRP Billing, should I still use the modifiers U2 and U3 in addition to using the GT/UB modifiers? Also some counselors are still seeing clients face to face, must I still bill using the GT or UB modifier?

The U2 or U3 modifier is required for all non-residential PRP claims submissions. In addition, If the PRP service is rendered by telehealth using accepted video protocols, the claim is submitted with the GT modifier; if the PRP service is rendered by telephealth using an audio only telephone, the claim is submitted with the UB modifier. If all PRP service encounters for the month for a given individual have been rendered in-person, then only the U2 or U3 modifier is necessary.

Regarding financial stability and billing, are there reserve funding limitations?

No additional limitations have been placed.

Where can staff find training resources and information on using PPE?

On its website the CDC has webinar trainings for healthcare professionals. It also has instructions for putting on and removing PPE.

Where can I find a list of federal COVID-19 information about substance use disorders?

The Office of National Drug Control Policy COVID-19 fact sheet provides links to important substance use disorder information from various federal agencies such as the DEA, SAMHSA, CMS, and HHS.

How can we ensure that patients do not lose the ability to use public transportation to get to their clinic as restrictions are being imposed on public transportation?

The Governor's executive order, dated March 30, 2020, restricts travel to that necessary for the conduct of essential business or the participation in essential activities. Travel for the purpose of seeking or participating in medical or behavioral health care is considered an essential activity; however, in order to mitigate the risk of COVID-19 exposure and transmission for clients and staff, most essential health care services may now be delivered by various health care modalities. If in-person treatment is essential, providers might consider providing clients with a form to carry when traveling to health care services to certify that such travel is essential.

Can you please advise if the March 21 directives include Level 3.7 Substance Use Disorder Treatment programs for LCSW-C, LCADC and LCMFT?

Level 3.7 SUD residential treatment is a medically monitored intensive level of service. It is important that a staff member appropriately trained to address immediate clinical needs of the residents be present in the residence at all times. Clinicians providing individual therapy may provide the service via telehealth, or voice-only telephone, if telehealth is not available. An update since March 21 is that within residential settings, group therapy may also be provided by voice-only telephone, but outside of residential settings voice-only groups are not authorized.

For programs not accepting any new admissions, is anyone at MDH going to give us guidance on these decisions? What is the plan for residential programs?

Residential providers should work with your local health department and local behavioral health authorities regarding any changes to business practices. MDH and BHA have issued the following guidance related to residential and congregate facility settings.

- Interim Guidance on Procedures to Prevent and Respond to COVID-19 in Small Group Home or Congregate Facility Settings
- Guidance for Recovery Residences and Residential Rehabilitation Programs
- Guidance for ASAM Residential SUD Treatment Providers During the COVID-19 Outbreak
- Telehealth Guidance for SUD Residential Treatment Services During the COVID-19 Outbreak

Given the Governor's announcement how are we to handle the requirement that there cannot be more than 10 people together, are we to cease our 3.1 and IOP operations?

IOP group services may be provided by telehealth but not by voice-only telephone. Individual services may be provided by either telehealth or voice-only telephone. Voice-only telephone may be used only if the individual is not able to access telehealth services. Social distancing should be practiced in the 3.1 residential treatment programs as well. If any individual exhibits symptoms, they should be separated from the others. See also:

- Guidance for ASAM Residential SUD Treatment Providers During the COVID-19 Outbreak

- Telehealth Guidance for SUD Residential Treatment Services During the COVID-19 Outbreak

- Guidance on Telephone/Telehealth Services Authorized for Intensive Outpatient SUD Programs During the COVID-19 Outbreak Service Rules For SUD IOP (LEVEL 2.1)

UPDATED Have there been any restrictions placed on substance use disorder recovery residences? I assume empty beds are to be used to help with COVID-19 cases, but I'd like to get a message out, if it's accurate, that if you are in recovery or have a substance use disorder and need help there are still places to go.

At present, recovery residences are not being asked to hold empty beds for individuals infected with the COVID-19 virus. Certified recovery residences that are interested in serving individuals in need of residential SUD treatment who test positive for COVID-19 should contact BHA or their local behavioral health authority.

Since fingerprinting locations are now closed, can we use private background check companies in order to move forward with hiring?

Even before the COVID pandemic, many Public Behavioral Health System funded agencies were experiencing difficulty obtaining fingerprint-based background checks because CJIS had taken the position that information would only be released to governmental agencies; BHA lacks the capacity to handle these reports. For background checks for those serving minors, it is recommended that providers attempt to obtain the checks through schools or other governmental sources with whom staff have working relationships. Failing this, provider organizations should perform background checks using private companies to investigate criminal records in all of the states in which the applicant has lived and worked. In addition providers should check with Maryland Judiciary Case search, as well as the OIG and Medicaid exclusion lists, along with the Board of Nursing exclusion list for Certified Nurse Assistants (if applicable).

Can Medicaid/BHA/Optum relax the weekly hour of service requirements for level 3s (SUD)? Due to a maximum of 10 clients per group, residential treatment programs are not staffed to provide more groups at the required number of groups per week.

A residential, low-intensity level 3.1 provider shall provide therapeutic services for a minimum of five hours per week. A level 3.5 provider shall provide therapeutic activities from 20 to 35 hours per week. A level 3.7 provider shall provide a minimum of 36 hours of therapeutic activities per week.

Will MDRN clients be eligible for extension?

While approval of extension requests for MDRN recovery housing services is normally restricted to very limited circumstances, BHA issued guidance, dated April 10, 2020 related to requests for continuing authorization of MDRN recovery housing services in order to ensure that MDRN participants continue to receive necessary services during the COVID-19 pandemic.

Will licensing continue and can the length of stay increase for those in treatment in a residential substance use treatment facility?

Length of stay is determined by the clinical need for the level of service, and if a lower level of care is readily available.

Will the Administration be allowing the ASO to authorize additional time for individuals for whom the Residential provider can not find a placement and they may clinically no longer meet Residential 3.3 criteria?

Length of stay is based upon medical necessity and whether there is an appropriate lower level of care for the patient. In this case, at minimum, the individual should be discharged to a 3.1 Level of Care.

The residential SUD treatment programs are starting to have increasing difficulties meeting the COMAR requirements for service hours across the various levels of care. Is there some possibility of reasonable flexibility around the service hour requirements?

Residential SUD treatment programs may provide certain clinical services by telehealth. Audio-only telephone care is allowed if telehealth is not available for individual and group therapy for individuals in a residential SUD. Group therapy may be by telephone if all the participants reside in the same home. In addition, the required number of hours certain clinical staff must be at the residence has been decreased, and the hours of therapeutic services have been modified in some instances. Please see the guidance on residential SUD treatment.

Can you please advise if the March 21 directives include 3.7 Treatment Recovery Centers for LCSW-C, LCADC and LCMFT?

Yes, LCSW-C, LCADC and LCMFT may conduct individual or group therapy by telehealth or telephone in a 3.7 Treatment Recovery Center.

We expect ongoing referrals from BHA, but what should we do if a BHA referral arrives with a high fever and seems symptomatic for COVID-19? Would BHA expect us to allow the client in?

As a prerequisite for final acceptance of referrals to residential settings, referral sources with health care staff (emergency departments (ED), clinics, detention centers, inpatient units, residential treatment centers (RTC), etc.) should screen the client referred for possible COVID-19, as per the Centers for Disease Control and Prevention (CDC) guidelines.

In addition to symptom questions, the screening should include a temperature check. The temperature check should be daily beginning with the initial referral until the time of their last contact with the client and should be communicated to the receiving program. The receiving program should also screen per the CDC guidelines immediately upon arrival, whether there have been previous screenings. Clients and referral sources should understand that admission to a residential program may be denied if there are positive findings in screenings before or upon arrival. The decision to deny admission should be made in consultation with medical staff. If a medical decision is unable to be made until arrival, an alternative plan should be established for the client that is consistent with CDC recommendations, including transportation.

For facilities who serve older adults please see MDH's Recommendations for Infection Control & Prevention of COVID-19 in Facilities Serving Older Adults.

Is it possible that BHA will stop all placement activity for a period and there will be no new intakes?

Any possible COVID-19 mitigation strategy designed to protect medical health would have to be carefully thought through if it potentially puts behavioral health at risk.

Does BHA have a position on temporarily limiting or restricting visits for residential treatment centers? For example, declining an overnight visit from a patient's children and approving an abbreviated visit instead.

We support this particular visit restriction plan, since it replaces the overnight visits with an abbreviated visit, balancing the risk versus benefit for the family. Following CDC guidelines, as part of the visit, the children should be screened for COVID-19, as should all visitors to a residential health care setting. The use of phones or other technology for videoconferencing should also be considered as appropriate to replace visits, especially if visits have to be suspended. If consents are in place for other agencies already involved, such as Child Protective Services, as appropriate they should be notified about changes in the visits.

What emergency plan should we follow if there is a community outbreak or surge?

Jurisdictions are advised to use their All Hazards Plan and Continuity of Operations Plan (COOP) which includes a list of essential functions. Please be sure the essential functions include the primary person responsible for carrying out the function as well as backup persons and what information is needed to maintain operations. It is the responsibility of the local addictions authority (LAA), core service agency (CSA), and local behavioral health authority (LBHA) to work with their local health department regarding closures and alternative arrangements, if any. BHA will provide a copy of the BHA Surge Plan to an LAA/CSA/LABHA, if requested.

What if I have a question about testing for COVID-19?

Information can be found on the MDH website in their FAQs on COVID-19 testing, including about the VEIP sites for drive-through COVID-19 testing. Patients can also call their doctor, or if they do not have a doctor, call 211.

Providers have expressed staffing concerns with houses staffed 24/7. Are there resources for outsourcing care to community agencies for Certified Nursing Assistant (CNA) support?

As of March 19, the CDC allows asymptomatic healthcare personnel (HCP) with an exposure to continue to work under specific circumstances if they wear a mask. The CDC guidelines state, "Updating recommendations regarding HCP contact tracing, monitoring, and work restrictions in selected circumstances. These include allowances for asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program."

Both LBHAs/CSAs and Residential Rehabilitation Program (RRP) agencies are required to have an All Hazards Plan and COOP which anticipate staffing shortages in the event of an emergency. It is critical that the LBHAs/CSAs coordinate their planning efforts with residential providers within their jurisdictions to ensure that contingencies are in place for staff coverage. In an emergency, not all staff functions are critical; thus, agencies should plan for alternative coverage by cross training their staff members. For example, if the onsite psychiatric rehabilitation program (PRP) is closed, PRP day program staff can be redeployed to staff the RRP. This is the time to build on the strengths and natural supports of residents who are doing relatively well (e.g., residents of General Level RRP) so that more staff time can be allocated to residents who are vulnerable and most at risk.

Providers are encouraged to develop innovative staffing models to meet immediate and short-term staffing needs. This may include pooling or sharing of staff across health care programs or providers with no known infections or enlisting agency volunteers or Board members to serve in administrative or supportive roles in order to free up staff to provide direct care. The LBHA and CSAs should continue to engage RRP providers to assess staffing needs and to identify community resources. If a jurisdiction anticipates that a certain RRP will no longer be able to provide 24/7 staffing coverage, the BHA Clinical Services Division should be immediately

notified. If a resident is subject to conditional release and is required by judicial order to have 24/7 coverage, then any staffing reduction may not occur without judicial consent. It is BHA's expectation that RRP providers work collaboratively with the LBHA/CSA and, as applicable, the MDH Office of Court Ordered Evaluation and Placement to ensure that RRP residents receive needed services and that such services fulfill any requirements that may exist as part of a resident's conditional release orders.

As an additional resource, Maryland Responds is a medical reserve corps that may be able to provide support. MDH has a list of Maryland Responds contacts by jurisdiction.

What should a provider do if clinicians do not present to work due to illness or care for family members or children with potential school closure?

Clinicians have an ethical obligation not to abandon their clients. If a clinician is unable to continue to provide needed care to a client, the clinician should facilitate a warm transfer to another clinician. Clinicians are expected to triage their caseload to determine the nature and intensity of services needed.

Designated essential personnel may find child care programs using LOCATE: Child Care, a free service available by phone Monday–Friday at 877–261–0060 between 7 a.m. and 7 p.m. Specialized services for parents of children with special needs, as well as Spanish language, are also available on these platforms.

The childcare programs established by the State are at no cost to designated essential personnel only. Children attending the state-funded childcare programs will be kept an appropriate distance from each other with ratios of a minimum of one teacher and nine children for school-age with smaller class sizes for younger children.

Parents are strongly urged to keep children at home as the first and best option to protect them from the virus.

Additional information is available on the MSDE Division of Early Childhood webpage.

Is there service delivery support on medication-assisted treatment (MAT) prescribing?

The State Opioid Treatment Authority is providing guidance to opioid treatment programs (OTP) and working closely with the Maryland Association for the Treatment of Opioid Dependence (MATOD). The Substance Abuse and Mental Health Services Administration (SAMHSA) has also provided guidance for OTPs that allow for increased take-homes. Also, BHA is distributing OTP FAQs.

Clinics limiting hours or services?

For non-OTPs this is determined by the LBHA/CSA/LAA and clinic provider. Any changes in provider services should include as appropriate the referral of clients to another program or alternative manner of providing services to clients in crisis. If a program is planning on closing or suspending all services, the Provider must pursuant to COMAR 10.63.06 submit a plan to BHA which must include how clients will be notified and transitioned to other programs, an emergency number for the provider, and location of medical records.

Any OTPs requesting clinic hour or service changes must receive approval from SAMHSA and the SOTA, who then notify the LBHA/CSA/LAA. However, at this time, limiting hours or services at OTPs is not being routinely authorized without sufficient justification. OTPs need to maintain normal hours in the event guest dosing is needed.

Will it be communicated that there is mandatory social distancing for providers that are offering round the clock care?

There is already guidance in effect from the CDC, SAMHSA, and MDH.

Will BHA suspend fidelity reviews for dates of services delivered for evidence-based practices during the state of emergency?

CMS announced that it is suspending non-emergency survey inspections in order to focus on the most serious health and safety threats like infectious diseases and abuse. BHA will likewise suspend all fidelity reviews for evidence-based practices.

Will providers have to submit their emergency preparedness plan for COVID-19 to the Maryland Association of Behavioral Health Authorities (MABHA)?

The LBHA/CSA/LAA in cooperation with the local health department should be working with their providers to ensure that an emergency preparedness plan is in place and up to date. As to avoid multiple and sometimes contradictory messages, the provider should communicate directly with the local behavioral health authority.

Although the Governor recently signed an executive order allowing the delivery of alcohol, access to alcohol could still decrease with in-person business no longer allowed at bars and restaurants. How can the issue of alcohol withdrawal be addressed?

ASAM has released a draft Guideline on Alcohol Withdrawal Management. It includes a section on ambulatory withdrawal management, which now also can be done via telehealth.

What should health care professionals know about waiting room management?

The CDC provides information for healthcare professionals on its website.

What should I know about infection control?

The Centers for Medicare and Medicaid Services (CMS) has issued several statements recently with regard to infection control, patient care, and provider safety precautions in a variety of settings. CMS provides screening guidance for Home Health Agencies, Nursing Homes, Hospice Agencies, Emergency Medical Team, etc.

The CDC has provided general interim infection prevention and control recommendations in health care settings. Also:

- Anyone with symptoms of a respiratory illness (e.g., cough, sore throat, fever, runny nose) should be given a mask before entering the space and throughout their visit or, if a facemask cannot be tolerated, use a tissue to contain respiratory secretions.
- Provide alcohol-based hand sanitizer with 60-95% alcohol at the front desk and elsewhere.
- Undertake routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label).
- The CDC has provided a further description of coronavirus symptoms, including emergency warning signs, along with an interactive Self-Checker guide to help someone make decisions and seek appropriate medical care.
- Another CDC update is that a cloth face covering should be worn whenever people are in a community setting, especially in situations where you may be near people, for example to the grocery store, pharmacy, or for a healthcare appointment. These face coverings are not a substitute for social distancing.

Are custom-made or homemade masks or gowns something that is recommended for healthcare professionals if PPE facemasks or gowns are not available?

Separate from CDC recommendations for the general public on wearing non-PPE cloth face coverings in public settings (Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission), the CDC does recommend using other mask options for health care professionals as a last resort, if PPE facemasks are not available (Strategies for Optimizing the Supply of Facemasks).

Similarly the CDC recommends non-PPE gown options as a last resort (Strategies for Optimizing the Supply of Isolation Gowns).

How does the COVID-19 outbreak affect the current system issues providers are having with the new ASO, Optum Maryland?

BHA recognizes that many Maryland providers may face financial issues as a result of the state of emergency. BHA and Medicaid have loosened regulations surrounding telehealth and telephonic services to ensure that individuals may continue to receive medically necessary services, as well as assist providers. Medicaid and Optum continue to work hard to address the various issues around their authorization and claims payment systems and still plan to have them operational in the near future.

Access to MAT and prescribing needs: If a consumer presents at the hospital with COVID-19 and they had been at their agency, how do they share with the HD all the individuals that may have encountered the sick individual? Do they release their list of clients? Is this a HIPAA violation?

HIPAA regulations have been relaxed in an effort to address the emergency medical needs of the patient. The Health Department will provide guidance. The agency could advise or use the following language to address this, "A fellow client (unnamed) has tested positive for COVID-19, and they should self-monitor and self-quarantine for symptoms for 14 days". The Health Department may broadcast to the public that a patient at the agency tested positive, that the patient was last at the agency on such date and time, and likewise advise all to self-monitor and self-quarantine.

Universal Correspondence and Updates for Providers: Communication/Conference Call Scheduling

BHA will provide FAQs weekly. Information will be disseminated through provider alerts and posted on the BHA website.

Support with Optum Communications with COMAR and Regulatory/Billing Code allowances during COVID-19

Medicaid and BHA are in regular communication with Optum to discuss regulatory and billing code allowances during COVID-19. Provider Alerts posted on Optum's website and disseminated by email will note the billing codes.

Would BHA be opposed to the systems manager (local) conducting a desk compliance audit in lieu of a face-to-face compliance audit for a Coordinated Care Organization (CCO) providers who may or may not have had a Quality Improvement Plan (QIP) or Technical Assistance Requirement (TA) requirement in the past year?

Unless an emergency situation exists, all face-to-face audits are suspended until further notice. The systems manager may utilize a desk audit, or if appropriate, a telephonic interview.

Are there any adjustments to the REMS program requirements and the blood testing for the prescribing of clozapine?

Yes. The FDA has released COVID-19 guidance on REMS.

Can you provide guidance on symptoms: withdrawal versus viral symptom presentation distinction?

The most common symptoms associated with the coronavirus are fever, cough, shortness of breath, and breathing difficulties. In more severe cases infection can cause pneumonia, severe acute respiratory syndrome, and even death. The World Health Organization provided additional guidance.

Withdrawal symptoms from substance use differ based on the type of substance and dose and even though they may include runny nose, sweating, muscle aches, or chills, they have other features that help distinguish them from respiratory illnesses. The World Health Organization has provided information about withdrawal. The National Center for Biotechnology Information also provided clinical guidelines for withdrawal management and treatment of drug dependence in closed settings.

Will there be a page on the BHA website for Health Departments?

The MDH dedicated coronavirus page provides information for Health Departments.

Is there standard guidance on screenings?

The CDC provides guidance on preparation, symptoms, and treatment. The CDC recently added a coronavirus self-check feature that asks a series of questions to establish the level of illness being experienced by the user or the person under investigation.

Is there any guidance available on the unique needs of PRP and RRP service recipients?

BHA and Medicaid have issued a provider alert advising when and how PRP services may be provided by telehealth or telephone.

Is there any guidance for residential programs should someone become infected? Will they be able to bill for services if someone is quarantined and not receiving traditional services required at that level of care?

If a client is residing in your program is quarantined, the program should make every effort to continue to provide some services. Payment will be permitted as long as the client resides in the program, and no alternative placement is viable for clinical or safety reasons.

Can BHA create a separate COVID page on its website?

BHA has a COVID-19 webpage.

Can SOR funds be used to assist with training, calling cards, phones, and to hire additional staff?

SOR funds may be used to provide training, to obtain calling cards in order for providers to render approved telephonic and telehealth services to SOR enrolled individuals. Providers may purchase telephones for the purposes of collecting GPRA data, however the purchase of phones to provide to individuals being served is not allowed. Funds can also be used to assist SOR funded providers with hiring additional staff to provide services within the scope of SOR initiatives.

Can BHA coordinate a call about the potentially growing homeless population?

BHA will continue to work with the Department of Housing and Community Development and Department of Human Services on meeting the needs of individuals experiencing homelessness especially during this state of emergency.

The CDC has developed the following guidance for unsheltered individuals experiencing homelessness and individuals in shelters. The National Health Care for the Homeless Council and the National Alliance to End Homeless also have guidance for serving individuals experiencing homelessness.

Are PRP agencies considered to be an essential business or non-essential business? Are we expected to limit our hours of operation at our office and work remotely to ensure social distancing or do we continue to work normal hours from our office site?

PRP's are considered health care facilities and are not required to close or limit their hours. The PRP may operate from its office or remotely as described in provider alert dated March 21, 2020, COVID-19 #4C.

What happens if the staff of a recovery residence has to self-quarantine and how do they address that and make sure people have what they need in the recovery residence?

BHA has shared the following correspondence that may prove helpful to Recovery Residences and hosted a COVID-19 Stakeholder Engagement call on March 25, 2020.

- PowerPoint COVID-19 Guidance for Communities, Business, and Schools
- Guidance for Recovery Residences and Residential Rehabilitation Programs
- Letter to BH Community
- Recovery and Wellness Resources

Could you please advise if/how the executive order issued by Gov. Hogan, impacts the treatment process for outpatient mental health agencies in any way?

Information on who is allowed to render services using the allowed variances is included in the COVID-19 4B document. It included the following with a direct reference to OMHC's:

- "Psychiatrists
- Psychiatric Nurse Practitioners (CRNP-PMH)
- Advanced Practice Nurses (APRN-PMH)
- LCPC, LCMFT, LCADC, LCPAT
- LCSW-C
- In Outpatient Mental Health Clinics–only under supervision–LMSW or LCSW, LGPC, LGADC LGMFT, LGPAT
- In ASAM Level 1 outpatient SUD program, State licensed providers only – CAC-AD, CSC-AD
- FQHCs who bill through the Specialty Behavioral Health System

Providers listed above must be enrolled in the Department's Speciality Behavioral Health Program."

Licensed Psychologists have been added to the list of eligible professionals above.

Regarding financial stability and billing, what should we do to support extended leave/sick leave for staffing?

BHA supports the CDC guidelines regarding healthcare settings.

Are custom-made or homemade masks or gowns something that is recommended for healthcare professionals if PPE facemasks or gowns are not available?

Separate from CDC recommendations for the general public on wearing non-PPE cloth face coverings in public settings (Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission), the CDC does recommend using other mask options for healthcare professionals as a last resort, if PPE facemasks are not available (Strategies for Optimizing the Supply of Facemasks).

Similarly the CDC recommends non-PPE gown options as a last resort (Strategies for Optimizing the Supply of Isolation Gowns).

With hand sanitizer getting more and more difficult to find, is there an alternative?

The CDC provides recommendations on Hand Hygiene in Healthcare Settings.

I am supposed to bring on a new prescriber in two weeks. Fingerprinting is shut down. What do I do?

A provider should detail in the new employee's personnel file that the individual was hired during the state of emergency. Utilize the Maryland Judiciary Case Search, Federal Exclusion List, and Maryland Medicaid Exclusion List; if no actions are found, you may bring on the new staff member.

Additionally, the provider should consult with the appropriate licensure board to determine if any actions are pending or have been made against the applicant's license. After the state of emergency has been lifted ensure that the fingerprints are processed.

RRPs and PRPs are looking for additional guidance—providing services, managing medications, etc.

RRPs and PRPs should do what they can to maximize physical distance. Where possible, services should be provided through telehealth/telephone. There are some circumstances in which staff will have to meet with participants. In order to ensure safety, hygiene, etc., to the degree possible, physical distance should be maintained, and safety precautions taken, including hand washing, use of disinfectants, etc. Participants should also be encouraged to maintain at least a six-foot distance from one another, and to follow proper hand-washing techniques, etc. The

Centers for Disease Control and Prevention (CDC) guidelines have recommendations for patients, healthcare professionals, and healthcare facilities.

Can a grant funded provider use grant money for personal protective equipment (PPE)?

Not without permission by the grantor. The request for PPE should be made to the LBHA, CSA, or LAA that granted the award. The LBHA, CSA, or LAA can make a request through MEMA for PPE. If MEMA agrees to support the procurement, MDH will do the procurement. There also is other additional funding available via other federal grants that could be used.

BHA has received approval from the Substance Abuse and Mental Health Services Administration (SAMHSA) to use State Opioid Response (SOR) funding to cover the cost for lock boxes and bags for safe storage of medication, mask, gloves, sanitizer for individuals enrolled in SOR funded initiatives. All requests for SOR funds for PPEs should be submitted by the local behavioral health authority to ATTN: SOR Project Director at BHA.

The jurisdiction's grant award will need to be amended to permit the expense.

What should we tell consumers who are concerned about access to services?

Individuals who are concerned about how to access services may contact their local behavioral health authority, core service agency, or local addiction authority. If an individual is experiencing a behavioral health crisis, they may call 211, press 1.

Individuals who are deaf or hard of hearing seeking information about COVID-19, may also access information at the Governor's Office of the Deaf and Hard of Hearing.

If a grant funded provider overspends due to increased costs because of the required COVID-19 response, will they be made whole at the end of the fiscal year?

The grant funded provider needs to have received permission from the LBHA, CSA or LAA that granted the funds prior to overspending.

Will there be some kind of mechanism for grant funded providers to be reimbursed for increased costs?

The grant funded provider needs to be in communication with and have received permission from the LBHA, CSA or LAA that granted the funds for additional funding for the increased costs. The grant award can only be spent up to the approved grant amount.

As an organization that provides in-home Applied Behavior Analysis across Maryland, Pennsylvania, and West Virginia, we are seeking clarification on continuing to provide in-home services to children and adolescents with autism spectrum disorder in the State of Maryland.

Maryland's Office of Legal Counsel has provided Interpretive Guidance on March 23, 2020. Organizations providing support for persons with intellectual or developmental disabilities are included in the federal critical infrastructure sector. Therefore, services may continue to be provided. Organizations should follow CDC guidelines when providing services to protect individuals and staff from infection to the greatest extent and take steps to reduce the likelihood of infection.

A resident works in the hospitality field, if he gets laid off is there any funding to help him?

Individuals who have been laid off due to COVID-19 should follow guidance issued by the Department of Labor, Division of Unemployment Insurance.

Clients are trying to leave and are not abiding by curfew. Are we able to enforce sanctions?

The Governor's Order halts evictions related to Covid-19 and the Chief Judge of the Court of Appeals has issued an order staying all eviction proceedings and courts are not hearing failure to pay rent proceedings. The spirit and intent of the Court of Appeals order is to reduce housing uncertainty, homelessness, and transmission of COVID19 at this time. The Department is asking all providers to avoid discharge except in the case of serious violations which threaten the health or safety of other individuals in the facility.

In the event of an act of violence or threat of violence, property destruction, and ongoing harassment, the commissioner's office is still hearing peace order and protective order cases. Whether a peace order will put somebody out of the home is going to be up to the jurisdiction and the facts of the case, but a violation of a peace order is grounds to call the police and have the individual arrested and removed from the premises.

In the event of a violation of residential provider rules concerning illegal or illicit substance use, if a clinical program must complete a clinical discharge, they must follow the requirements of the accreditation standards and Code of Maryland Regulations, as well as guidance provided by their local jurisdiction's Office on Homelessness, Housing, or Human Services (or similar) regarding hospital or other facility discharges of homeless populations. Individuals should be screened before discharge and screened for housing stability and availability and referred appropriately to a shelter accepting individuals if they do not have a home to go to. The Department asks all providers to follow all recommended best practices at this time.

In the event that a Recovery Residence needs to evict a tenant from the program, if a program carries out such an eviction, they must be aware that this may be considered a violation of Maryland law and/or of the spirit of the order halting evictions, depending on the provider, the jurisdiction, and the circumstances, and could open the provider up to future liability based on the damages suffered by the individual, such as homelessness, exposure to Covid19, or even death. The Department recommends any provider looking to evict a tenant/client at this time consult legal counsel for advice on next steps.

Will BHA provide financial support for supplies during COVID-19?

There is a process to get supplies through MEMA. The LBHAs, CSAs, and LAAs are the point of contact for this. There is also additional support allowed through some federal grants.

Due to problems with having the capacity in step down level of care, can Optum be more flexible with extending the lengths of stay? What flexibility can Optum offer?

If there is no less restrictive placement or appropriate lower level of care available for the individual, Optum can authorize length of stay extensions. If the individual is in inpatient care, administrative days will be permitted. In addition, Optum may be able to advise the provider of lower levels of care willing and able to accept the client.

How should providers document the consent of video and phone services?

Written consent is not required; however, the provider should document in the client's record that the individual was advised that the session is being conducted by telehealth/telephone, that the transmission may not be HIPAA compliant, etc., of the possible security and confidentiality issues that exist, that there is an option to opt-out, and that the individual consented to the service.

What level of proof of call, other than progress notes, should be kept for auditing purposes of video and phone services? Phone audits were mentioned. What does that mean?

Providers must be willing to provide telephone records of services, if requested for an audit. Phone records may be in the form of invoices/call records from the telephone service provider. These must be retained by the provider and produced, if necessary, to justify services.

How will audits of telephone and video services be conducted and what records will auditors be looking for?

Providers must maintain documentation in the same manner as an in-person visit or consultation, using either an electronic or paper medical record. Providers must also reflect in their records whether the service was delivered using telehealth or telephone and note that the client was advised that the service was being provided by telephone or video and gave informed consent. Providers must also be willing to allow inspection of telephone records of phones used to provide services.

What technology can be used for new assessments? What should not be used?

Video telehealth technology should be used when available for new assessments, but if not audio-only telephone is permissible. Initial evaluations of new OTP patients prescribed methadone still require an in-person evaluation.

Are there prior authorization steps for providers using audio-only, video and telehealth? Can we get clarity from someone at the ASO (Optum) about that?

Telehealth (4b) Guidance: No special telehealth authorization is required for approved telehealth and approved telephone services. Authorizations proceed according to normal, non-telehealth, practices.

Providers are no longer required to enroll in telehealth in order to provide telehealth services as long as they are enrolled as a Medicaid provider. The provider does not need to obtain a separate authorization to provide telehealth services.

Telehealth, video or phone for groups – which is allowed?

Video telehealth should be used for all groups and family therapy if available. If not, family therapy is allowed via audio-only telephone. Group therapy within residential settings may be provided by audio-only telephone if telehealth is not available, but outside of residential SUD or RRP settings audio-only groups are not authorized.

HIPAA and State compliant telehealth should be used whenever possible. However, the U.S. Department of Health and Human Services has relaxed HIPAA requirements to allow the use of telehealth non-public facing technology such as Skype, Zoom, Doxy, WhatsApp and similar apps. This does not apply to public-facing applications such as FaceBook Live, Tik-Tok, and Snapchat, which can easily be shared to a broader audience. Technological services hold inherent privacy risks. For example, Zoom recently experienced security issues.

There seems to be no guidance related to the PPHP level of care. That is a group modality. In this attachment they state to BH providers NOT to do groups, this would functionally close

my PPHP services for the hospital and potentially drive up psych admissions. Do you know who I could speak with at MDH/BHA about this?

Groups should only be provided in person with great caution. They should be limited to less than 10 people and carried out within other CDC guidelines, which includes social distancing of six feet and the wearing of cloth masks. Groups can instead be provided through telehealth as discussed elsewhere in this FAQ. The clinician must be able to see the individual, and the individual be able to see the clinician and other participants. Outside of residential settings audio-only groups are not authorized, but within residential settings may be provided by audio-only telephone if telehealth is not available.

In regard to the proof of telehealth for all services, will Zoom calendar meeting logs suffice for proof of the contact?

The Zoom calendar information should be retained, as well as the clinician's documentation in the individual's chart that the service was conducted by telehealth and the individual consented to the service being provided by Zoom or any other technological service.

Technological services hold inherent privacy risks. For example, Zoom recently experienced security issues. Providers should ensure the service recipients are fully aware of security/confidentiality risks when engaging in remote health services. The form of transmission (e.g., HIPAA-compliant Zoom software) should be documented in the medical record and that the individual consented to the particular method of remote health services with the understanding that it may not be fully compliant. Other documentation as required by law should also continue.

Are there prior authorization steps for providers using audio-only, video and telehealth? Can we get clarity from someone at the ASO about that?

The Provider does not need specific authorization to provide services by audio-only or video technology. Provider would obtain authorization as if the service was being provided in-person.

Can the timeframe where Medicaid authorizations are not required for outpatient mental health be extended beyond the end of April? Incedo is still not consistently functioning properly.

Per Medicaid: The grace period for providers to enter authorizations for dates of service from the beginning of the Optum contract forward will be extended for six months following the reactivation of the Optum system. Providers will be notified of the reactivation date to determine the duration of the six-month extension period. **Providers must continue to enter authorizations** to reduce authorization backlog. Keeping authorization submission current

allows Optum to update and enhance the authorization system to support the provider experience. Several system updates will be implemented throughout April and May. Providers should make sure they are registered to receive provider alerts as updates are continually communicated via alerts. You can also obtain past provider alerts from the Optum Maryland website.

For Supported Employment, can we bill the PRP contacts under it – there was no guidance for this and the current modifiers will not allow for it.

On April 1, 2020, BHA issued guidance related to the telephone services authorized during the state of emergency for supported employment (SE) services.

I am in the process of a CARF accreditation, which is scheduled to be completed in May. Is BHA still approving licenses for new practices at this time?

If a new provider has completed the accreditation process, and submits a completed application, the application will be reviewed for licensure. Otherwise providers will have to wait for the accreditation organization to provide them with accreditation. Existing accreditation-based licenses are being extended to the end of the state of emergency and will be extended as necessary to meet the site-visit schedules of the accreditation organizations.

PRP are considered essential business and are not allowed to close, and we are providing services to our clients through telecommunications. Can we be open but closed to the public?

The PRP may provide all services via telehealth, and individual services by voice-only telephone if telehealth is not available. The office may be closed, however there must be a way for clients and potential new clients to contact the office and speak with the provider.

Is there a directive or protocol recommendation from BHA regarding individuals discharging back to Residential Rehabilitation Program (RRP) from community hospitals? Given the health needs of our RRP folks, there are usually a handful or more across programs that go to the hospital for somatic issues.

RRPs should be following guidance from Maryland Department Health's Congregate Housing Guidance and from CDC.

Clinical therapy staff are working more from home through telephonic connection and not office based. What impact does this have on COMAR 10.21.20.10(2b) requiring the Medical

Director to be onsite for 20 hours? Will this be waived during the emergency period declared by the Governor?

Prior to COVID-19, the medical director 20 hour per week on-site requirement unique for clinics certified as outpatient mental health centers was already able to be met by telehealth due to a statutory change last year. During this emergency, this requirement will continue to exist, although, in the absence of telehealth capability in some instances, medical directors may provide care via voice-only telephone.

Can we please be sure to emphasize how fragile our provider networks are at this time. The difficulty with the Optum transition has already taxed our providers financially and this pandemic is putting a lot of jobs and organizations at risk. I am hoping that BHA leadership is able to advise all of us on how we can survive through this without losing a lot of providers, further putting PBHS consumers in jeopardy.

BHA is aware of the financial burden placed on providers, as well as the clinical issues being presented by COVID-19. This FAQ and the Telehealth FAQs detail the expansion of Medicaid reimbursement for telehealth and audio-only telephone services due to COVID-19. The Maryland Small Business COVID-19 Emergency Relief Grant Fund offers working capital to assist Maryland small businesses and nonprofits with disrupted operations.

The Small Business Administration's Economic Injury Disaster Loan Program provides loans to qualified entities that are impacted by the COVID-19 crisis.

The Federal Paycheck Protection Program (PPP) is an SBA loan that helps businesses keep their workforce employed during the COVID-19 crisis. Contact your lender to determine if they are an SBA-approved lender. Loans will not be issued by financial institutions that borrowers do not have an existing relationship with. The application is online. Lenders may also require additional information or a separate application. Please contact your lender ahead of time to determine if they are prepared to issue loans.

We have a provider of residential addiction services that says at least four of her nurses are going to request FMLA related to the Families First Act. She is afraid many of her other staff will follow suit. Do you think she meets the exception of being a "Healthcare Provider"? Any advice or guidance?

Please see the U.S. Department of Labor's website for guidance on the Act.

I have not received approval as a Medicaid provider; I am a provider for UHC. How does it work if someone has Medicaid and UHC and requests my services? Thank you.

In order to receive reimbursement for behavioral health services, you must be enrolled as a Medicaid provider. Please contact Optum Maryland for assistance in locating a Medicaid provider: (800) 888–1965.

Is there any guidance available on provisional status substance use counselors?

Alcohol and Drug Trainees may provide services via telehealth as set forth in the Secretary of Health's directive.

How should we manage pre-existing health conditions with consumers and older adult clients?

MDH has guidance available for older adults and health care facilities on how to manage pre-existing health conditions for older adults.

There are programs who have a "no admit" hold for the next two or so weeks. This means they are not doing interviews or taking in any new admissions for at least the next two weeks. We therefore have inpatient clients that we are unable to step down.

SAMHSA is advising that outpatient treatment options be used to the greatest extent possible, because of the substantial risk of coronavirus spread with congregation of individuals in a limited space such as in an inpatient or residential facility. Outpatient providers can conduct new patient assessments by telehealth, and if not available, by audio-only telephone. An exception is OTP new patient assessments when methadone is prescribed, which still requires an in-person evaluation.

The local behavioral health authority in the county you are seeking to discharge the patient to can be contacted to advise you of programs accepting admissions.

If we have to decrease hours how can we provide group sessions and is that realistic?

Please see the Provider Alerts governing various behavioral health programs. The alerts set forth which services may be provided by telehealth or telephone. In addition, the alerts advise if any other services rules have been relaxed.

Will training be available on how to use PPEs?

Guidance on the proper sequence to don and doff a PPE is provided by the CDC.

Is there any direction to contractors regarding working during the COVID-19 emergency? For example, for those with a valid reason not to work (chronic serious medical condition and/or lack of childcare due to COVID-19 closures), are we supposed to attempt to replace those contractors with temporary workers?

Programs are expected to make every effort to continue providing clinical services to its clients, including hiring temporary or contractual employees if appropriate and able.