VERMONT

COVID-19 FREQUENTLY ASKED QUESTIONS AND GUIDANCE TO DESIGNATED AGENCIES

DEPARTMENTS OF MENTAL HEALTH & DISABILITIES, AGING AND INDEPENDENT LIVING

While the situation continues to rapidly evolve, we want to provide as much information as possible to you at this point regarding impacts of COVID-19. Please review the information below carefully and distribute it to your staff and partners as you deem appropriate. We recognize additional detail will be necessary in some areas and guidance may change in the coming days and weeks. We will share further information as clarification becomes available. ***If the Vermont Department of Health subsequently releases any direction that differs from the guidance below, the VDH direction takes precedence.*** ***This document is updated frequently, and new information is in red text.***

VERMONT

GENERAL GUIDANCE

WORKFORCE

WORKPLACE SAFETY

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

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

ESSENTIAL HEALTHCARE WORKERS

The press release from the Governor's Office defines designated agencies as essential:

> *Essential persons are defined as:*
> - *Providers of healthcare including, but not limited to, workers at clinics, hospitals, Federally Qualified Health Centers (FQHCs), nursing homes, long-term care and post-acute care facilities, respite houses, VNAs, **designated agencies**, and emergency medical services;*
> - *Criminal justice personnel including those in law enforcement, courts, and correctional services;*
> - *Public health employees;*
> - *Firefighters;*
> - *Vermont National Guard personnel called to duty for this response;*
> - *Other first responders and state employees determined to be essential for response to this crisis under the State Emergency Operations Center; and*
> - *Staff and providers of childcare and education services (including custodial and kitchen staff and other support staff) for children of other "essential persons."*

ESSENTIAL SERVICES

For the Executive Order issued March 25, 2020 as it applies to mental health programming, all Designated Agencies, Specialized Service Agencies, residential treatment programs (PNMI), therapeutic foster parents and shared living providers are considered "healthcare service providers" and "caregivers" of essential services.

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

All in-person service delivery must follow precautions previously set forth and found in the Home-Based Service Delivery Guidance on the Department of Mental Health website.

Examples of "essential services" include:

- *Emergency Examinations for involuntary hospitalization*
- *Crisis stabilization/ hospital diversion programs*
- *Residential treatment programs, including group homes, staffed living and intensive residential*
- *Therapeutic Foster Care/ shared living homes*
- *Psychiatric Services*
- *Nursing services*
- *Food availability*
- *Obtaining essential home supplies related to health and sanitation*

NON-ESSENTIAL SERVICES

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

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

- *Case Management/Service Coordination*
- *Community Supports*
- *Non-urgent Therapy*
- *Respite*
- *Supported Employment*
- *Day Services*

DEVELOPMENTAL DISABILITY SERVICES- ADDITIONAL INFORMATION ABOUT ESSENTIAL SERVICES

DAIL sent additional information to providers in a memo in order to more clearly define what providers and services are considered to be essential in light of the Governor's Stay Home, Stay Safe Executive Order.

For Developmental Disability Services, in some cases Service Coordination, Community Supports and Respite are Essential In-Person Services.

Service Coordination

Regular check-ins by the service coordinator to the individuals on their caseloads need to happen, especially for individuals receiving 24-hour residential supports. These check-ins should happen at a minimum weekly by phone, Skype, Zoom Meeting or other appropriate electronic means. The type and frequency must match the needs of the individual and be flexible to meet this need as it changes.

While the majority of supports associated with Service Coordination can be provided remotely via phone conversation, Skype, Facetime, Zoom Meeting or other video conferencing services, there remain some vital services and supports that must be done via in person contact. Examples of these include response

to emergency or crisis situations resulting from the individual becoming dysregulated and in-person support to assist the individual and their support team help him/her self-regulate and ensure the safety of the individual and those supporting him/her, providing assistance with police, rescue squad and other public supports that have become involved in the situation, support if the individual needs to be taken to the ED for evaluation of physical injury, illness or psychiatric concerns. Service Coordination may need to be done in-person with individuals living independently if they are in a crisis situation that might result in eviction from their home, the need for welfare checks when there has been a lapse in regular contact, when potential exploitation or abuse is suspected to have happened and the individual needs support to process and report it. Basically, In-Person Service Coordination should be occurring when the level of need is more than or not appropriate to happen via verbal or video contact.

Community Supports

For some individuals, receiving regular, planned community supports is vital to their routine and ability to regulate their lives and behaviors. For these individuals, having regular, planned community supports is key to helping them maintain their home and those relationships that are important to them. Without these routines and the activities within them, the person's ability to self-regulate their emotions and behaviors can become more difficult, thus placing their safety and that of those around them in jeopardy. For some, the opportunity to get out into the community to places and participate in activities they enjoy is a time to relax, focus on things of interest and participate in things that are meaningful to them, some of which include activities that give back to their community. It also gives the individual and their family, shared-living provider or residential staff a needed break in which they too can relax and attend to things and activities that they can't while having to maintain attention and awareness of the individual and what is happening in the home. Not having these supports can place the home and associated supports in jeopardy.

It might be possible to have some of the community supports provided in a flexible manner, where instead of the staff taking the person out of the home, they could check in with the individual per usual schedule and maybe engage in an activity within the home or an alternative setting like a walk in the neighborhood, basketball in the local outdoor courts, hike in the woods or other venue with few people and the ability to practice social distancing.

The key is to engage in activities that meet the individual's needs while providing meaningful support and a routine which both the individual and his/her family, shared living provider or residential support can rely on.

Respite

For some individuals, families and shared living providers respite is an essential service. The regular break it provides helps maintain the ability for the individual to remain living in the home. Without it, not only is the home and ability to remain living there in jeopardy, in some cases the very safety of the individual and those s/he lives with is in jeopardy. For these people, the break allows the provider and themselves to let their guard down, relax and recharge so they can effectively provide the intense, 24/7 awareness of the person and their needs that it requires to keep them safe and productive.

For all of the above services, the agency and individual's team will decide when it is essential and provide the service based upon that team determination. As such billing for the service provided will be allowed and done using the guidance that is being provided going forward.

REMOTE WORK

Recommendations from the Governor about remote work were primarily for state employees, however, the logic about reducing exposure and transmission of illness still applies for others. If an employee cannot work remotely, consider rotating in-person work schedules so that folks are not all together at the same time when in the office. General information about novel coronavirus and precautions are available here: *https://www.healthvermont.gov/response/infectious-disease/2019-novel-coronavirus*

SERVICE DELIVERY

TRANSPORTATION OF CLIENTS

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

DOCUMENTATION REQUIREMENTS

Current recommendation is to reduce minimum documentation to client, time/date, and service for general Medicaid mental health services, with basic, bulleted notes.

For any client identified with suicidal ideation or risk of harm to self or others, notes pertaining to the clinical need and safety planning must be documented.

These recommendations around minimum documentation by AHS do not supersede more stringent requirements each agency's compliance officer and leadership may put into place. It is critical to assure enough documentation is happening to provide for the safety of clients, especially at a time where meetings and updates may not be an option and providers may be relying on documentation for information.

Master Agreement performance measure and VBP reporting will have deadlines extended and targets will need to be reevaluated. We will provide more guidance on this as things develop, but we understand and expect that data will be irregular and incomplete during this time reflecting a major shift in practice.

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

PROVIDER ENROLLMENT

CMS Health Care Provider Fact sheet addresses what the emergency declaration allows for Provider Enrollment. Please speak to their attorney to assure compliance with the CMS guidance. See DAIL FAQ section of this document related to flexibility in performing background checks.

CARING FOR COVID-19 POSITIVE PEOPLE

The Vermont Department of Health website contains the most recent (CDC) information and guidance for health professionals on working with this population. AHS will continue to monitor and advise as necessary.

SUPPLIES AND EQUIPMENT

If you anticipate depletion of any COVID-19 specific resource stocks within the next 7 days, please submit a resource request (link is external).

Completion of this COVID-19 resource request form assumes facility implementation and practice of Contingency Operations Personal Protective Equipment Conservation (PPE) measures. PPE conservation measures are based in part on the CDC's Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response(link is external) (published 03/05/2020).

Homemade masks are not considered personal protective equipment, but in settings where face masks are not available, health care providers may use them as a last resort.

INFRASTRUCTURE AND STAFFING

If an individual being supported by our agency becomes ill and it is suspected that s/he may have COVID-19, what do we do?

Providers need to follow the guidance as outlined by the Vermont Health Department regarding who should be tested. Consult Joy if there is a question on this. If it is determined that the individual needs testing and is tested, it is considered a Medical Emergency per the CIR Guidelines and a CIR must be submitted. Subsequently, when the test results are received with a positive diagnosis, then a follow up CIR must be submitted. If the test results are negative, then no follow up is required, but notification should be sent to Joy so she is aware of the negative results.

How do we locate housing in the event that we have no place for someone?

In this unprecedented time, Agencies should call their regional developmental disabilities specialist so that we can triage and think with you about the best resources in your area and statewide. We are currently working on the best ways to coordinate housing responses. In order to expand housing options during the VT COVID-19 State of Emergency, DAIL is offering the option for requesting an exception to the maximum number of individuals in a Shared Living Provider setting, as follows:

Exceptions to the maximum number of individuals served in Shared Living Provider settings:

According to State Licensing rules, any home providing services to three or more residents must be licensed.

If an Agency seeks to allow a Shared Living Provider home to start serving three individuals on a temporary basis, in order to ensure availability of living arrangements during the State of VT COVID - 19 state of emergency, they may submit an exception request to the Commissioner of DAIL via Liz.Perreault@vermont.gov.

Any request for exception to licensure for a Shared Living Provider serving more than two individuals should ensure the following considerations are addressed:

1. *The request is made by the Agency.*
2. *The Shared Living Home has adequate resources to meet the needs of all individuals served, including a separate room for each individual served, in order to support physical distancing and potential need for future isolation.*
3. *The change in living arrangement is voluntary and acceptable to the individuals receiving services and any guardian of each individual.*
4. *There is a plan for transition back to long term living arrangements, after the novel coronavirus crisis has passed.*

Please note the following additional considerations:

- *Home inspections- Consistent with prior guidance regarding home inspections, please request an Emergency placement using the guidance for Emergency Placement in the Housing Safety Inspection Protocol. This still requires the agency to do the pre-inspection to make sure the basic safety requirements are in place. If a housing inspection was previously completed, and the rooms were not included in the inspection at that time, only the "new" rooms will need to be inspected.*
- *Any exception to licensure granted by the DAIL Commissioner as a result of the novel coronavirus crisis is short term in nature and is not presumed to continue after the crisis has ended.*

Can there be a statewide communication about suspension of certain services? Examples- community supports and supported employment. 1:1 direct supports?

DAIL has published guidance that describes the provision of essential vs. non-essential services that is located here. See also the flexibility section below for more information.

When can folks go into the community?
It is recommended that all people avoid going into the community as much as possible. Visits should be limited to ensuring essential supports rather than social events.

Agencies are concerned about the potential loss of shared living providers – many need more respite due to reductions in services.

If respite is available within the budget, this may be moved around, if this represents an additional expense, we are developing an expedited process to approve short term additional funding. See also the flexibility section below for more information.

Some staff are not working and some staff are wanting to work. What is the commitment from DAIL to be able to pay folks?
It is our priority to keep agencies whole by not requiring the suspension of services. This should maintain the Agency's ability to continue to pay staff.

We are also looking to the Department of Labor related to unemployment supports, should those become necessary.

Finally, DAIL is exploring what emergency funds may be made available through actions of the Vermont State Legislature and through Federal means.

What if there is disagreement on the team about going out into the community? What is the guidance on who has the right to decide?

It is expected that services will be planned with an individual and their guardian to determine the best viable options. The Agency can decide what they're able to support related to health

and safety and employee capacity. The Agency must support individuals and guardians with information to understand the risks involved. Individuals receiving services and/or their guardians may then make their own decisions as to their own actions and must be able to grieve or appeal the Agency decision if there is a significant disagreement as to available supports.

Individuals can outreach Vermont Legal Aid as well as DAIL at: Questions about Novel Coronavirus with any concerns about health and safety risks related to temporary service changes.

FLEXIBILITIES/TEMPORARY SUSPENSION OF USUAL REQUIREMENTS

Can background checks for known individuals be waived? For example, if the check has been completed for one employer, can it be waived for the next person?
Background checks must continue to happen for staff and for independent support workers, however, if an independent support worker shifts to a new employer, background checks do not have to be completed again if they were done within the last 90 days.

Can some DAIL- DDSD oversight activities be temporarily suspended?
Yes, we are temporarily suspending Quality Reviews and National Core Indicator (NCI) surveys.

What about home visit and frequency guidelines?

DDSD is temporarily lifting the face-to-face home visit requirement except when determined necessary to assure an individual's health and safety. A "home visit" may be performed using remote communication such as Zoom, Skype, Facetime or the phone, with an emphasis on assuring the health and safety of individuals served and communication that is accessible to the individual and/or their guardian. Now that everyone has been ordered to stay home and stay safe, these check-ins by the service coordinator must happen at least weekly. Check-ins may need to happen more frequently depending on the individual situation, this is a decision that needs to be made by the individual and his/her support team, including the guardian.

What about housing inspections if folks need to be moved around, can we get variance on inspections?

If it is essential a person move into a new shared living home during this period, the inspection can be postponed but the following must be in place.

1. *The pre-inspection must be completed by the agency's assigned person (service coordinator) to ensure as well as can be done that the home is safe.*
2. *Fire safety/escape plans developed and in place.*
3. *The inspection/assessment needs to be entered in the Housing Safety Inspection Portal, which may prompt a Emergency Placement request. (which we will approve).*

We can't grant variances from the inspections, but we can make some accommodations. Those accommodations can include the length of time and Evergreen is willing to continue with inspections and have training in safety and health precautions to limit their spreading of COVID-19 or any other similar viral infection. They are following the guidelines set out by the Health Department and will check in the day before all scheduled inspections to verify no one in the home is sick or vulnerable. They have reached out to all agency housing contacts with specific information around this.

What about getting ISA signatures for addendums to ISAs? Will we have to get ISA changes signed?

On a temporary basis, the requirement for getting an ISA signature for changes is removed. Please note that the approval signatures do need to be obtained when the current situation and need for self-quarantine & associated precautions pass. In the meantime, the addendums to the ISA must be discussed with the person and guardian as applicable by phone, Skype, Facetime or the option that works best for the team and verbal or visual approval obtained. The process must be documented by the service coordinator in their notes and on the ISA form in the approval section. Once face to face meetings resume, signatures or the typical method of approval by the individual, guardian, and other key team members needs to be obtained.

DDSD has been asked if this guidance pertained to New ISAs, ISA reviews and ISA Modifications. The answer is yes, this guidance does pertain and the key is documenting the process and need for obtaining approvals in an alternate, verbal or visual, manner due to the current pandemic.

A question was asked about using electronic signatures similar to ones used by banks, contracts and other legal documents. If your agency has the ability to access and use the technology required for these types of gathering secure electronic signatures via e-mail, then that is an acceptable way of obtaining them.

A question was also asked about using a 30-day extension to continue the current ISA with the Outcomes and supports identified in it. That is acceptable using the process described above. It also might be a better option considering that no one knows how long the current restrictions will last to create a simple, short term ISA as described in the ISA Guidelines for up to 90 days that says the team has decided to continue the current ISA Outcome and supports while focusing on maintaining the health & safety of the individual. The meeting and approvals will then be handled using the above guidance.

What about the 14-day suspension rule?

We are suspending the suspension rule until after this crisis abates.

Further clarification regarding suspensions, terminations and submission of monthly HCBS spreadsheets

Agencies will need to continue to submit monthly spreadsheets during Vermont COVID-19 State of Emergency, however, DDSD is allowing the following flexibilities starting with the March spreadsheet:

- *As is currently the practice, you may move funds around within an approved budget to meet the needs of eligible individuals. This includes changes to implement restrictions on going into the community and meeting face to face. You may also temporarily shift funds between individual budgets. The following new flexibilities also apply:*
  - *You are not required to complete a new needs assessment to implement these changes or restrictions required by the Governor's Executive Order.*
  - *These changes in service do not need to be reflected on the monthly spreadsheet.*
- *The requirement to suspend services when there is a gap in service greater than 14 days as described on page 53 the SOCP is also suspended. The following new flexibilities also apply:*
  - *You do not need to suspend billing for those services.*
  - *These gaps in service do not need to be reflected on the spreadsheet.*

Additional considerations-

- *Your Agency must keep track of changes so that services can be appropriately readjusted after the Vermont state of emergency ends.*
- *Information about changes must be provided to the to the individual/guardian and, as needed, to ARIS if there are changes to funding amounts.*
- *Agencies remain responsible for notifying individuals of their appeal rights for reductions in service.*

Are there other suspensions that still need to be submitted?

Please reference #2 on pages 52-54 of SOCP, the following suspensions are required as described:

- *Incarceration*
- *Nursing facility*
- *ICF/DD*
- *Psychiatric hospitalization Level 1 bed*
- *Leaves services*
- *Other circumstances*

Additional Flexibilities:

- *Other hospitalizations- we currently have CMS permission to allow some billing for up to 30 days. We are providing additional flexibility to allow agencies to continue to bill for **all** services in currently approved plan while a person is in a hospital (other than level 1 psych bed) and to extend beyond 30 days.*

- *Visits outside of VT – we allow for those services which are continuing while outside of the state to continue for up to 6 months. We will allow for the continuation of those services which are being provided to extend beyond 6 months when the person is unable to return to VT due restrictions to travel related to the COVID-19 State of Emergency.*

Note: *If services were already suspended in February, they should remain suspended unless the person resumes services as these suspensions were not related to the VT COVID-19 State of Emergency.*

Terminations:

Please reference #3 on pages 54-55 of SOCP, all terminations are required as described with the following exceptions:

- *If a person has an extended visit out of state that exceeds 6 months because the person is unable to return to Vermont due to the crisis and the suspension is extended, a termination is not required.*
- *For other prolonged suspensions exceeding 6 months, the agency can request an extension.*

Newly approved funding:

- *New funding approved from Equity or Public Safety must be added to the spreadsheet.*
- *If funds are being permanently moved from one person to another, these changes should be reflected on the spreadsheet.*

Documentation:

Agencies should follow standard documentation requirements for services, except as noted in this FAQ document or other communications from DAIL. The only additional documentation is that changes in people's plans of service/budgets should be noted in individual records.

Is DAIL moving forward with converting from a daily bundled billed code to a monthly code?

DAIL is working with providers on a monthly cash flow model for billing to start on 7/1/20. This is to create a more efficient and streamlined process for managing spreadsheets. DAIL did consider moving more quickly to a monthly billing code to be used during the crisis, however, we have decided not to pursue that at this time due to time constraints. Our energies will be focused on the monthly cash flow model to start on 7/1/20.

Encounter data:

Agencies had been submitting encounter data for Home and Community-based Services (HCBS) to the MSR. Some agencies had moved some or all of their reporting to MMIS. Due to this partial implementation of reporting in MMIS, it is likely neither MMIS nor MSR will contain a complete record of services. In addition, due to the temporary flexibilities being provided above,

there is an increased likelihood of irregularities in encounter data. ***Therefore, DAIL does not intend to use encounter data as an accurate measure of service delivery during this Vermont COVID-19 State of Emergency. Agencies may stop all further efforts related to implementation of reporting in MMIS at this time.*** *If reporting is currently automated, providers may choose to continue reporting encounter data. DAIL does not t expect agencies to undo any system changes that have been put into place. If you are receiving denials related to encounter data for HCBS, DAIL does not expect you to spend time on correcting and resubmitting those encounter claims at this time.*

What about Critical Incident Reports (CIRs)?
CIRs are a key monitoring and tracking tool for all individuals receiving DDSD HCBS services but most importantly the over 1,000 individuals receiving 24-hour residential supports. As such DDSD is requiring that these reports continue to be sent in with priority for APS/DCF reports, Deaths of individuals receiving services, Medical Emergencies, Missing Persons and Potential Media.

While we are working from home and don't have the normal abilities to complete, print or sign the CIR, can we simply upload the unsigned in pen document as a pdf document?
The important thing is to have the CIR and information submitted so sending in the form with the appropriate names and titles of people, especially those people directly involved in the incident, written or typed on the form is acceptable as long as they're legible. The contact information for the people listed must also be on the form for potential follow up questions. There also needs to be a statement documenting that the incident was discussed with supervisors/QDDP. If this is in place, then the signatures and comment from the QDDP as well as all other signatures can be added later.

PAYMENTS AND DOCUMENTATION

What do we do if we're using folks in flexible ways? Can we avoid the ISA and spreadsheet changes?
The Development Disabilities Division has determined that the following flexibilities are warranted and immediately available to Agency providers.

1. *Agencies may temporarily move community and employment support lines over to home supports, service coordination and respite. The staff that were providing community and/or employment supports should be considered as potential providers of home supports, service coordination and respite as those needs are increasing as a result of these shifts.*
2. *These changes can occur without a needs assessment, however, service coordinator notes should include the change.*

3. *The Division and Agencies should be focused first and foremost on ensuring the health and safety of those we serve. The Division is determining what streamlined process may be used for new proposals and increased needs.*
4. *Agencies may flex the above-mentioned services within the person's currently approved budget and without submitting the spreadsheet. Encounter data that does not match the approved plan are permissible in this instance. Note that Agencies will need to track this internally, however, in order to take and move funds, and notify ARIS so that spending authority is updated.*

What will happen to payment if there is atypical encounter data, i.e. it is not consistent with approved funding?
We are temporarily approving changes that would result in a difference between the approved plan and the documented encounters. This is acceptable within the bounds of the flexibilities and documentation expectations described above.

Can one-time funds be used to pay for remote technology, i.e. ipad?
Per the System of Care Plan, One-time funds can be used to meet the assistive technology needs of an individual receiving services to support continued services, communication and community connection related to COVID-19 limitations.

Please put on hold DS payment reform and the RFP for doing the new assessments process and tool. We are not requesting a delay in implementing the new cash flow model.

The DS Payment Reform project is being put on hold until further notice. DAIL will not be requiring any additional work on this project at this time to allow agencies to focus on delivering critical services. DAIL will continue to work with providers on implementing the new cash flow model as this may realize administrative efficiencies for providers and the State.

DMH: FREQUENTLY ASKED QUESTIONS

COVID-19 AND MENTAL HEALTH—VERMONT DMH IS HERE.
Mental Health Information for Individuals, Families and Providers **(UPDATED DAILY HERE)**
Send Questions to: AHS.DMHCOVID19Info@vermont.gov

WORKFORCE

Please support our ability to have all clients, as well as our staff, tested easily and to have access to health care to keep the provider community calm and intact.

These are in limited supply and being prioritized through the VDH process.

OPERATIONS

Can state employees fill positions at DAs to help with staff shortages?
The state cannot commit to staffing our partner agencies at this time. Variables would depend upon the vacant position, availability of qualified individuals at the state, and the arrangement meeting the current requirements of providing services.

Can the state assist in identifying alternate facilities if any of our facilities need to be shut down for disinfecting?
We understand this is concern and we are working to address this.

COMPLIANCE

Please confirm the types of video conferencing that are HIPAA compliant.
Please refer to the HHS guidance here.

When is adherence to HIPAA necessary – i.e. is HIPAA compliance required for conversation between person living at an SLP and their family members?
This is a question that DAs need to consult with their own legal resources on. AHS cannot provide legal advice on this matter.

Can quality reviews be suspended for now?
Yes, we are temporarily suspending Quality Reviews.

MEDICAL CLEARANCE AND TRANSPORTATION REGULATIONS

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

Transportation of people in need of inpatient psychiatric admission who are waiting at a location other than an Emergency Department.

Medical necessity is required for Ambulance transport. If there is no danger to self or others then a regular, non-emergent transport should be pursued. Information about these rides can be found at: https://dvha.vermont.gov/sites/dvha/files/documents/providers/Forms/1nemt-manual-1.1.19-final-.pdf

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

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

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

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

The Drug Enforcement Agency has allowed Doctor's to use telemedicine to prescribe controlled substances since declaring a state of emergency in January 2020. This service still requires the doctor follow the telemedicine/telehealth protocol of having both video and audio capability. Psychiatrists are encouraged to regularly check the American Medical Association, American Psychiatric Association, and Drug Enforcement Agency websites for updates. A link is provided with detailed information: ***https://www.deadiversion.usdoj.gov/coronavirus.html***

Can the two-year Re-assessment requirement for DMH Medicaid clients be waived for the balance of 2020? Also, what about extending Medicaid IPC longer than currently required?
Reassessments and IPC's due for an update in the next 90-days can be postponed. We will continue to review this timeline as the situation progresses.

FINANCE

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

In collaboration with the Billing Mangers the following guidance will be followed: H2017 and H2015 services will use POS code 53 (CMHC) as it has been since telephonic services have been

allowed for these codes. H2011 (Emergency Services) will continue to be coded as it has been as both telephonic and in person has been allowed for this service. All other services that are approved for MHPR will use POS 99 for any telephonic services that are being provided beginning on 3/23/2020 and will continue until we are no longer shifting service provision in response to COVID-19.

Can payment for EMR implementation be expedited to DAs that would reimburse those who have already implemented or are in the process?
Yes, DMH is working now on fully releasing these funds.

Can additional temporary bundle funding be added for high risk clients requiring frequent contact?
We understand this is a concern and we are working to address this.

An additional item that will become extremely important will be the need for dollars to be spent on items typically not allowed by Medicaid. We will need to do very unusual things and room and board type of expenses will be among them.
We understand this is a concern and we are working to address this.

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

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

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

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

- DMH PROVIDERS: *Programs that exist outside of DMH's case rate are those most at risk given they do not benefit from the flexibility of the case rate as noted above.*

- RESIDENTIAL/PNMI: *Providers bill a daily rate that is computed by Rate Setting based on historical utilization and cost. This daily rate may or may not cover the cost of providing services to the individuals placed at the facility. Providers are able to submit a request for extraordinary financial relief (EFR) if the daily rate does not cover the cost. The state has some flexibility to approve a request that considers the cost of underutilization due to extraordinary circumstances.*
  Update 3-27-2020: Our primary goal is to support programs to have cash flow to maintain their staff and provide services to youth. The mechanism is to be finalized. There is a recommendation to the Division of Rate Setting (DRS) that they are drafting, then it will be reviewed by PADS, and then DRS will need to get the final authorization to implement. We recognize programs are decompressing, some children are returning home while others are remaining in program. Those decisions are made on an individualized basis based on the clinical presentation, availability and safety of the home (or foster home), and an in-depth process with the family. We are looking at a funding model that our PNMI crisis programs use – like Jarrett and Depot – where they get paid 100% based on average utilization and daily rate is determined by monthly census (so can fluctuate). Again, this is not finalized and may not be the final approach.

- *There are two adult residential facilities outside of the case rates, Second Spring North and South. Quarterly payments are sent to the provider with a year-end cost reconciliation, and any unspent funds beyond a 1.5% gain is returned to the State. If the cost of the facility is not covered by the quarterly payments, DMH has the flexibility to provide more funding as needed within available resources.*

SCHOOL-BASED SERVICES

Success Beyond Six providers were issued a memo on March 19, 2020, updated 3/26/2020, detailing specific SB6 issues related to service delivery methods, match payments, billing and reimbursement. You can find this on the DMH website.

These changes are effective during the period of Governor Scott's Executive Order for school closure and continuity of learning through remote means. DMH will continue to coordinate with Agency of Education to refine guidance for school mental health with the new order to develop and implement continuity of learning plans for remote learning for the remainder of the 2020 school year.

SERVICE DELIVERY

What restrictions have changed for service delivery?

Medicaid already allows some services to be provided by phone, including Community Supports and Service Planning & Coordination which are the most commonly used services under SB6. DVHA alleviated other restrictions to allow telehealth (video/audio) and telephonic (audio only)

service delivery under broader authority due to COVID-19. That specific guidance can be found here. SB6 services may be provided through telehealth or phone with the student and/or family in their home or chosen setting and are not required to be in-person in a school setting.

"Live Chat" within remote learning platforms without audio or visual is not a covered method of service delivery at this time.

DAs should coordinate their plan for service delivery during the school closure period with their LEA/SU/SD to make sure there is agreement. Determination of service delivery should be based on clinical need, family availability and ability to access supports through alternate methods, and adherence to the Executive Orders. Guidance for determination of Essential Services can be found here.

The State recognizes that many providers are experiencing financial difficulty as a result of the Executive Orders. Please know that DMH is working with AHS to identify paths for financial relief for providers in this situation.

Agencies are looking at other ways of deploying SB6 staff to support other service delivery. DMH supports this practice to ensure that necessary services are available during this period when staffing is limited due to COVID-19 impacts. A staff provider can provide services under two case rates provided that the services delivered through the each are guided by separate goals on a plan of care and distinctly delivered from the services provided through the other.

AOE Guidance

AOE guidance to schools for Covid-19 is here. In the Q&A document there was this information below, again please discuss with your LEA/SU/SD.

If we have outside contractors who are willing to continue serving students if the schools close, should we do that? Some contracted providers are offering, and some are not.

a. It depends. If the service can be provided using social distancing recommendations, then it should be provided (virtual or phone).

b. Any in-person service is subject to the Vermont Dept of Health and the CDC recommendations.

c. This also applies to ALL related services

Can SB6 providers continue to offer in-home services if families are open to it?

DMH noted the Essential Worker list includes DAs and Stay at Home order allows essential healthcare to continue. See DMH Essential Services guidance and VDH guidance for Home Based Services.

Compensatory Services

Compensatory services (under Special Education) will likely be needed over summer & vacations for students on IEPs. AOE is still developing this guidance. VSA/VCSEA's concern is whether the DAs will be able to provide MH supports during any compensatory service education days. Please discuss with your LEA/SU/SDs.

FINANCE AND BILLING

The State recognizes that many providers are experiencing financial difficulty as a result of the Executive Orders. Please know that DMH is working with AHS to identify paths for financial relief for providers in this situation.

CERT revenue currently requires a 2-hour attendance minimum for our Independent Schools. We may be doing treatment support via phone, telehealth, or in home as appropriate so would like to request a waiver on 2-hour minimum to bill.

This was reduced to 15 min. of a qualifying service per day in order to bill the per diem rate

Please drop School Based Clinician Case Rate minimum from 2 hours to 30 minutes.

This was reduced to 1 hour of a qualifying service per month in order to bill the monthly case rate

Considering Emergency Case Rate for Behavioral Intervention Programs

DMH recognizes that the BI Programs are unable to provide the level of service as was typical fee-for-service billing during the school year. DMH/DVHA are exploring development of a case rate, while understanding the context of other emergency financial relief options. DMH sent a request to DAs to provide updated quarterly budget report, FTEs and # students in BI programs with ratios (detail of request in email) to assist in the development of a case rate. CFOs met Thurs 3/26/20 to discuss what is needed for case rate construction and will submit to DMH.

As soon as DMH has more information about our ability to create a BI case rate, and potential timeline to do so, we will share it.

Would this emergency BI case rate apply to ASD programming?

It would apply to the behavioral intervention services that have been billed FFS, so yes if that's how ASD services were provided (as opposed to CERT).

Please postpone match payments for SBS until after crisis is resolved

We discussed with AHS Central Office finance this request to postpone match payments for SB6. Any postponement of match could not extend beyond the fiscal year (June 30, 2020). Please communicate with DMH Business Office your agency's plan for match payments and agreements you have established with your LEA by April 13.