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GAVIN NEWSOM
GOVERNOR

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Behavioral Health Information Notice No: 20-009

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

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

REFERENCE: [DHCS COVID-19 Response website](#)

PURPOSE: Provide guidance on concrete steps counties and providers should take to minimize the spread of COVID-19, ensure ongoing access to care, and provide guidance on flexibilities given the [Section 1135 waiver](#) granted by the Centers for Medicare and Medicaid Services (CMS), effective March 15, 2020.

BACKGROUND: DHCS is issuing guidance to counties and Medi-Cal providers to assist them in providing medically necessary health care services in a timely fashion for patients impacted by COVID-19. DHCS was given authority to grant flexibility for certain requirements through Executive Order (EO) N-43-20. See [DHCS COVID-19 Response website](#) for information notices related other flexibilities.

This Information Notice covers:

1. Behavioral health services via telephone and telehealth (updated 4/9/20)
2. 5150 evaluations and 5151 assessments (new 4/9/20)
3. Adapting oversight requirements to prioritize patient needs and accommodate workforce challenges
4. Emergency enrollment in Medi-Cal for mental health providers (new 4/9/20)
5. Access to prescription medications
6. Alcohol and other drug (AOD) residential and outpatient treatment facility flexibilities (updated 4/9/20)
7. Temporary suspension of Mental Health Services Act (MHSA) program onsite reviews (new 4/9/20)
8. Process to request fee reductions or waivers (updated 4/9/20)
9. Canceling meetings and gatherings to prevent COVID-19 transmission.

POLICY

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

1. Behavioral health services via telephone and telehealth (updated 4/9/20)

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

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

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

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

Where telehealth is already allowable, DHCS does not restrict the location of services via telehealth. Patients may receive services via telehealth in their home, and providers

¹ DHCS has also released [guidance](#) to Medi-Cal Managed Care Plans regarding COVID-19.

² For more information, see [MHSUDS IN 17-045](#).

may deliver services via telehealth from anywhere in the community, outside a clinic or other provider site. DHCS does not impose requirements about which live video platform can be used to provide services via telehealth.

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

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

[SAMHSA has also issued guidance](#) on 42-CFR Part 2 compliance during the emergency.

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

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

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

- ***Drug Medi-Cal Organized Delivery System: (updated 4/9/20)***
 - Starting March 1, 2020, through the duration of the emergency, the initial clinical diagnostic assessment, determination of medical necessity, and level of care can be conducted by telephone. These services may be provided by telehealth, or in-person, independent of the emergency.
 - Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
 - Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California's Medicaid State Plan does not require that all components of these services be provided in-person. (An example could include services via telephone for a patient quarantined in their room in a residential facility due to illness).
 - Currently, DMC-ODS individual counseling services that a provider determines to be clinically appropriate can be provided via telehealth and telephone. Beginning on March 1, 2020, and for the duration of the public health emergency, group counseling services can also be provided via telehealth and telephone in DMC-ODS counties.⁴
 - Services via telehealth are currently optional for counties in the DMC-ODS waiver, which expires on December 31, 2020. DMC-ODS counties that have NOT previously authorized services via telehealth in their program should allow providers to bill for services via telehealth during the period of heightened COVID-19 concern; DHCS approval is not required.
 - No additional billing code is required when submitting claims for services rendered via telehealth or telephone. The service provided should be claimed with the appropriate procedure code.

- ***DMC State Plan: (updated 4/9/20)***
 - Beginning on March 1, 2020, and for the duration of the public health emergency, individual and group counseling services can be provided via telehealth and telephone in DMC State Plan counties.⁵

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

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

⁵ Group counseling sessions may be conducted via telehealth and telephone if the provider obtains consent from all the participants and takes the necessary security precautions, in compliance with HIPAA and 42CFR Part 2.

- Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
- No additional billing code is required when submitting claims for services rendered via telehealth or telephone. The service provided should be claimed with the appropriate procedure code.
- ***Specialty Mental Health Services:***
 - Any service, including an individual or group service,⁶ that can be provided by telephone or telehealth is reimbursable in all counties (examples include mental health services, crisis intervention services, targeted case management, therapeutic behavioral services, intensive care coordination, intensive home-based services, medication support services, and components of day treatment intensive, day rehabilitation, adult residential treatment services, and crisis residential treatment services). Mental health intake/assessments may be provided through telephone or telehealth.
 - Licensed providers and non-licensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
 - Certain services, such as crisis stabilization, day rehabilitation, day treatment intensive, crisis residential treatment services, and adult residential treatment services, require a clearly established site for services and some also include in-person contact with a beneficiary in order to be claimed. However, not all components of these services must be provided in person.⁷ (An example could include services via telephone for a patient quarantined in their room due to illness).
 - Providers should add the telehealth billing modifier, GT, to identify that the specialty mental health service was rendered via telehealth. (See [Mental Health Services Division Medi-Cal Billing Manual](#), page 87-94 for more information). However, the Short Doyle system will accept and pay the claim even if the modifier is not attached to the claim. During the emergency, DHCS strongly encourages all counties to allow SMHS to be provided via telehealth and telephone, and if the county systems are not set up yet to add the modifier, claims may still be submitted and processed; the lack of systems in place to add the modifier should not be a barrier to the provision of services. The place of service code is not required for outpatient services, but is required for inpatient services.

⁶ Providers are still required to follow relevant privacy laws to ensure patient privacy protections.

⁷ See Title 9, California Code of Regulations, Sections 1840.318, 1840.320, 1840.332, 1840.334 and the California's Medicaid State Plan: Supplement 1 to Attachment 3.1-A – Targeted Case Management (TCM) Services for Medi-Cal Beneficiaries that Meet Medical Necessity Criteria for TCM Covered as Part of the Specialty Mental Health Services Program; Supplement 2 to Attachment 3.1-B - Rehabilitative Mental Health Services (Medically Needy); and Supplement 3 to Attachment 3.1-A - Rehabilitative Mental Health Services (Categorically Needy)

- ***Mental Health Services Act (MHSA)***: Counties may use MHSA funding to pay for services provided via telephone or telehealth as long as the services provided are consistent with the MHSA requirements and are not able to be covered by any other source of funding.

More information on telehealth can be found on the [DHCS telehealth website](#).

2. 5150 Evaluations and 5151 Assessments (new 4/9/20)

WIC 5150 evaluations may be performed by authorized providers face-to-face via telehealth as per WIC 5008(a). This may include releases from involuntary evaluation and treatment, as appropriate. These services are billable to Medi-Cal regardless of whether they are provided in person or through telehealth as long as the individual has Medi-Cal coverage for the service and all Medi-Cal requirements are met. That said, assessments required by WIC 5151 are to be completed “in person” and, as such, shall not be provided using telehealth.

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

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

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

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

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

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

In light of the many challenges counties are facing due to the COVID-19 crisis, including the inability to obtain a fire clearance, the DHCS is waiving the Medi-Cal Certification requirements for an onsite review and a fire clearance, during the approved 1135 Waiver period.

During this time, providers may be certified using the streamlined procedures outlined below:

- For initial certification of county-owned and operated providers, the County Mental Health Plan (MHP) shall submit an Application for Medi-Cal Certification (DHCS Form 1736), which includes a copy of the head of service license and Program Description for the provider.
- For re-certification of county-owned and operated providers, where the MHP conducts the onsite review, the MHP shall submit a MHP Recertification of County-Owned and Operated Providers Self-Survey Form (DHCS Form 1737), which includes a copy of the head of service license.
- For re-certification or change of address of county-owned and operated providers, where DHCS conducts the onsite review, i.e., juvenile detention center, crisis stabilization unit, day treatment and/or adding medication room(s), the MHP shall submit all updates via email to include a head of service license and Program Description, as needed.
- For re-certifications of contracted providers, the MHP shall submit a Medi-Cal Certification Transmittal (DHCS Form 1735).
- For DHCS tracking purposes the MHP shall note "COVID-19 Emergency Medi-Cal Certification" on whichever form is being submitted to DHCS for processing, i.e., DHCS Form 1735, 1736 or 1737.
- MHPs following these procedures will be granted enrollment for 60 days, retroactive to March 1, 2020.
- Please note that the 60-day emergency Medi-Cal Certification may be extended in 60-day increments in accordance with the 1135 waiver.

- Should the 1135 Waiver be extended, no further action will be required on behalf of the approved provider.
- Upon conclusion of the 1135 Waiver, the MHP will be required to submit any outstanding documentation and meet all certification requirements, including the requirement for onsite review and having a valid fire clearance.
- The MHP will have 180 days from the conclusion of the 1135 Waiver to conduct the onsite review and to submit any outstanding documents, including a current fire clearance.
- If due to unforeseen circumstances a county is unable to meet the 180-day time frame the county may submit a request for an extension of up to an additional 90 days.
- All required documentation and email communication must be submitted to DMHCertification@dhcs.ca.gov.

5. Access to Prescription Medications

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

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

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

DHCS will grant flexibility to Residential and Outpatient Treatment Facilities to allow ongoing access during the emergency. See Behavioral Health Information Notice (BHIN) 20-018, Alcohol and Other Drug Facilities, for more information, on the [DHCS COVID-19 Response website](#).

7. Temporary Suspension of MHSA Program On-site Reviews (updated 4/9/20)

Per W&I Code section 5897(d), DHCS is required to conduct MHSA program onsite reviews per county performance contracts to ensure compliance with regulatory, statutory and contractual language once every three years. Due to the public

emergency, the MHSA program onsite reviews have been temporarily suspended. Counties scheduled for a 2020 review will be contacted by DHCS to determine next steps for completing their MHSA program reviews and/or plans of correction.

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

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

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

- Identify whether the request is for a reduction or waiver of fee(s);
- Identify the type of fee requested to be reduced or waived (i.e., renewal application fee, relocation fee, etc.) and the specific fee amount being requested to pay if seeking a fee reduction;
- Describe how this reduction or waiver is specific to the COVID-19 emergency;
- Describe the economic hardship or displacement that occurred due to the emergency;
- Identify the provider type (MHRC, PHF, NTP, DUI, SUD Residential or Outpatient);
- Identify the provider number and legal entity name;
- Identify the program/facility name;
- Identify the facility physical address;
- Identify the facility mailing address; and
- Identify the Program Director and contact person.

See BHIN-15 MHRC and PHF for additional flexibilities granted to facilities during the emergency on the [DHCS COVID-19 Response website](#).

9. Meetings, Gatherings and Events

DHCS recommends that counties and providers follow guidance by the California Department of Public Health and limit unnecessary meetings, gatherings and events,

and convert all possible meetings into virtual (live video or telephone) events. Governor [Newsom's Executive Order N-25-20](#) provides guidance that meetings required to follow Bagley-Keene standards may be done virtually.

For this reason, DHCS is reaching out to training and technical assistance contractors and will consider no-cost extensions for events cancelled due to COVID-19, and encourages counties to do the same. Contracts funded by the Substance Abuse and Mental Health Services Administration must be obligated and expended by the end of the period of availability for each grant award.

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

Sincerely,

Kelly Pfeifer, MD
Deputy Director
Behavioral Health

Enclosure

DHCS COVID-19 Frequently Asked Questions: Behavioral Health

Updated April 9, 2020

Principles:

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

Intake & Assessments

- 1. May telehealth and telephone be used to place and release involuntary holds on individuals (5150 evaluations and 5151 assessments) and are these services billable to Medi-Cal? (New 4/9/20)**

WIC 5150 evaluations may be performed by authorized providers face-to-face via telehealth as per WIC 5008(a). This may include releases from involuntary evaluation and treatment, as appropriate. These services are billable to Medi-Cal regardless of whether they are provided in person or through telehealth as long as the individual has Medi-Cal coverage for the service and all Medi-Cal requirements are met. That said, assessments required by WIC 5151 are to be completed “in person” and, as such, shall not be provided using telehealth.

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

Yes. In anticipation of CMS’ approval of DHCS’s 1135 Waiver request, beginning on March 1, 2020 and for the duration of the emergency, the initial assessment of the beneficiary may be performed by telephone by a medical director, a licensed physician, a licensed practitioner of the healing arts (LPHA), or a certified alcohol or other drug (AOD) counselor. Outside of and during the emergency, this initial assessment can also be performed either face-to-face or via telehealth (STC 132.e; IA Section III.B.3.iv). The medical director, licensed physician, or LPHA must then use the information gathered in that face-to-face or telehealth assessment to establish a substance use disorder (SUD) diagnosis, medical necessity, and level of care (LOC) placement.

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

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

Operational Requirements

4. What services may be provided by telehealth? (Updated 4/9/20)

DHCS encourages all counties to permit telehealth services within state and federal requirements, given the importance of minimizing COVID-19 spread. In anticipation of CMS' approval of DHCS's 1135 Waiver request, beginning on March 1, 2020 and for the duration of the emergency, services via telephone and telehealth are now reimbursable in Drug Medi-Cal State Plan counties. Services via telephone and telehealth are available in DMC-ODS and for Specialty Mental Health Services, independent of the emergency. See the COVID-19 [Behavioral Health Information Notice 20-009](#), the [DHCS telehealth website](#) and the [DHCS Telehealth FAQ](#).

5. Can individual counseling services be provided via telehealth and telephone?
(New 4/9/20)

Yes. In anticipation of CMS' approval of DHCS's 1135 Waiver request, beginning on March 1, 2020, and for the duration of the public health emergency, individual counseling services can be provided via telehealth and telephone in DMC State Plan counties. Individual counseling may be provided in DMC-ODS counties and for Specialty Mental Health Services, independent of the emergency.

6. Can group counseling services be conducted via telehealth and telephone? If so, does the 12-client limit remain in place? (New 4/9/20)

Yes. In anticipation of CMS' approval of DHCS's 1135 Waiver request, beginning on March 1, 2020, and for the duration of the public health emergency, group

counseling services can be provided via telehealth and telephone in DMC State Plan counties. Group counseling services may be provided in Drug Medi-Cal Organized Delivery System and for Specialty Mental Health Services, independent of the emergency. However, providers must obtain consent from all the participants and take the necessary privacy and security precautions, in compliance with HIPAA and 42 CFR Part 2. The 12-client group size limit still applies in both DMC and DMC-ODS counties.

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

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

8. How can providers ensure their patients do not run out of medications?

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

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

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

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

This is a federal, not a state, issue. SAMHSA has released guidance that an initial evaluation by [telehealth or telephone is now allowed for buprenorphine](#). The DEA COVID website addresses all other controlled substances, which includes sedatives and stimulants, under telemedicine. Practitioners can start a new prescription for a patient who is already under their care by telephone, but cannot do so for a new patient without a telemedicine or in-person visit. For more information, see <https://www.deadiversion.usdoj.gov/coronavirus.html>.

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

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

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

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

Client Signatures, Consents and Privacy

12. Does DHCS have any guidance for counties on the expectation for client signatures on release of information (ROI), consent forms, or notices of privacy practices if services are delivered exclusively by telephone or telehealth? (New 4/9/20)

DHCS did not specifically request waivers of signatures on these items; therefore, we do not have specific guidance at this time. DHCS expects providers to document client consent in other ways if an in-person visit is not possible. That said, DHCS will continue to work to include information relevant to client signatures in [Behavioral Health Information Notice 20-009](#) and/or these FAQs as more information becomes available.

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

Yes. The Substance Abuse and Mental Health Services Administration (SAMHSA) issued [new guidance](#) which allows providers to share patient SUD diagnosis information that would normally be protected under 42 CFR Part 2 in instances of a bona fide medical emergency. Usage of the medical emergency exception must be documented by providers.

14. When the emergency ends, does DHCS expect that counties will go back and obtain treatment or client plan signatures for clients that are still in treatment? (New 4/9/20)

Counties are not expected to get signatures from beneficiaries who receive DMC State Plan and DMC-ODS services during the time period of the COVID-19 public health emergency. For Specialty Mental Health Services, MHPs may provide services through telehealth and telephone during the COVID-19 public health emergency and if beneficiaries are unavailable to sign their client plans, Section 1810.440(c)(2)(B) of Title 9 of the California Code of Regulations applies, which gives an exception to the signature requirement when the client is unavailable. When the public emergency ends, counties shall resume compliance with all requirements for obtaining treatment plan signatures on a “go-forward” basis. This means that following the COVID-19 public health emergency, counties shall obtain a treatment or client plan signature from all new beneficiaries and from existing beneficiaries when they resume in-person services following the emergency. Counties are not expected to obtain beneficiary signatures on treatment or client plans for beneficiaries that started and discontinued services during the COVID-19 public health emergency, or who discontinued services during the emergency period. During the COVID-19 public health emergency, Counties must document in the beneficiary’s medical record the reason for the missing signature.

Documentation

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

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

16. Is documentation of patient consent for telehealth or telephone services required during the emergency? (New 4/9/20)

No. [Executive Order N-43-20](#) states that the requirements specified in Business and Professions Code section 2290.5(b) related to the responsibility of a health care provider to obtain verbal or written consent before using telehealth to deliver services and to document that consent is suspended.

17. What about required signatures on other intake requirements, like admission agreements or consent for treatment forms? (New 4/9/20)

Counties are not expected to get required signatures from beneficiaries who receive DMC State Plan and DMC-ODS services during the time period of the COVID-19 public health emergency. For Specialty Mental Health Services during the COVID-19 public health emergency, MHPs may follow the guidance in #4 above regarding signatures on client plans. MHPs may suspend the requirement for patient signature for receipt of psychiatric medication during this time of emergency (Cal. Code. Regs. tit. 9 § 852). When the public emergency ends, Counties shall obtain signatures from all beneficiaries. Signatures should not be backdated. Beneficiaries should date the document when the wet signature is provided, and counties must document in the beneficiary's medical record the reason for the late signature. Counties are not expected to obtain signatures on these documents for beneficiaries that started and discontinued services during the COVID-19 public health emergency, or who discontinued services during the emergency period. During the COVID-19 public health emergency, Counties must document in the beneficiary's medical record the reason for the missing or late signature.

Data Reporting

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

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

- Consumer Perception Survey - The next scheduled survey period is May 2020. Due to the COVID-19 emergency, DHCS has rescheduled the survey collection period to June 22-26, 2020.
- Client and Services Information System (CSI), Data Collection and Reporting System (DCR), California Outcomes Management System (CalOMS) and American Society of Addiction Medicine (ASAM) Level of Care - DHCS recognizes that there may be delays in submitting data. However, due to

federal reporting requirements, DHCS is not able to waive data reporting requirements for CSI, DCR, CalOMS and ASAM Level of Care Data.

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

Provider Enrollment

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

DMC providers with DMC applications currently under review with PED can additionally apply for emergency enrollment pursuant to the [Guidance for Emergency Medi-Cal Provider Enrollment](#). Their pending non-emergency enrollment DMC applications will not be impacted. Moreover, providers enrolled pursuant to the provider bulletin will be automatically deactivated at a later date based on the duration of the emergency. If a provider would like to continue their enrollment as a DMC provider, they will need to submit a completed DMC provider application. If a provider currently has a pending non-emergency DMC application, it will continue to be reviewed in the order it was received, separately from any DMC application received pursuant to the emergency provider bulletin.

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

Pursuant to section 1135 of the Social Security Act (1135 Waiver) CMS has waived the enrollment requirement for SMHS providers to undergo an onsite visits per Code of Federal Regulations (CFR), title 42, section 455.432(a). Moreover, part of the enrollment process for SMHS providers includes the requirement for the provider to obtain a fire clearance prior to the onsite visit, as specified in the county Mental

Health Plan (MHP) contract. As stated under the MHP contract, Exhibit E, page 12 of 16, Paragraph 7(B), DHCS may use policy letters to provide clarification and instructions to its contactors regarding implementation of mandated obligations pursuant to State and federal statutes and regulations.

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

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

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

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

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

- DHCS Mental Health Licensing Section will work collaboratively with facilities to process a Criminal Record Approval Transfer Notification (CRATN). An additional criminal background check (CBC) is not required if an individual or

licensee has received a prior CBC clearance while working in a licensed facility and wishes to transfer to another similar facility. The individual or licensee who wishes to obtain a CRATN shall complete the DHCS Form 1818.

- An online criminal background check may be considered with the submission of the [DHCS Form 3007](#) and [DHCS Form 3085](#).
- Once the DHCS Form 1818 has been submitted to DHCS, the individual with a DHCS-issued CBC clearance is allowed to start working in a PHF or MHRC.
- As was the case before the COVID-19 crisis, a new employee who has submitted fingerprint images/live scans can start working in a PHF or a MHRC while awaiting the CBC clearance as long as the employee is under constant supervision.
- If the individual will solely be providing services through telehealth, and will have no direct contact with the patient, then a criminal background check will not be required.

Licensing and Certification

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

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

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

To address the issue of insufficient AOD SUD treatment bed capacity, the Licensing & Certification Division will expedite review and approvals of requests for increases in treatment bed capacity. Residential SUD treatment facilities seeking to increase treatment bed capacity shall electronically submit a Supplemental Application (DHCS 5255) along with a Facility Staffing Data form (DHCS 5050) for review to LCDQuestions@dhcs.ca.gov. DHCS shall also review and approve facility requests to temporarily operate above their licensed treatment bed capacity as long as the total bed capacity does not exceed the capacity allowed in the approved facility fire clearance.

For any specific operational flexibilities, including the need to operate above the licensed capacity for MHRCs and PHFs, requests may be made by email to: MHLC@dhcs.ca.gov. The request shall include the following written components:

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

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

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

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

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

General COVID-19 Information

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

[California Department of Public Health – COVID-19 Updates](#)

[CDPH Gathering/Meeting Guidance](#)

[CDC COVID-19 webpage](#)

[Guidance for the Elderly](#)

[Guidance for Employers](#)

[What to do if you are sick](#)

[Guidance for Workplace/School/Home Document](#)

[Steps to Prevent Illness](#)

[Guidance for use of Certain Industrial Respirators by Health Care Personnel](#)

[Medicaid.gov, COVID-19 resource page](#)

[CMS: Emergency Medical Treatment and Labor Act \(EMTALA\) Requirements and Implications](#)

[Governor Newsom's 3/12/20 Order](#)

[CDPH: For Individuals with Access and Functional Needs](#)

27. How should behavioral health programs reduce transmission of COVID-19?

The CDC has provided interim [infection prevention and control recommendations](#) in health care settings. Recommendations include:

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

28. How should behavioral health providers manage patients presenting with upper respiratory symptoms?

DHCS strongly encourages use of telehealth or telephone services to minimize infection spread. See COVID-19 [Behavioral Health Information Notice 20-009](#) for information about how specialty mental health and substance use disorder services can be delivered by telehealth or telephone, including in facilities where patients may want to access services by telephone even when needing to be isolated in their room.

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

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

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

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

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

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

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

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

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

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

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

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

- **Screen patients and visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering your healthcare facility.** Providers can refer to the following resources on the CDC's [Guidelines for patient screening](#) and [Infection Prevention and Control Recommendations](#) for more information.
- **Ensure proper use of personal protection equipment (PPE)**

Healthcare personnel who come in close contact with confirmed or possible patients with COVID-19 [should wear](#) the appropriate [personal protective equipment](#).

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