STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

March 20, 2020

To: Brian Ingraham, Vaya
Leza Wainwright, Trillium
Rhett Melton, Partners
Rob Robinson, Alliance
Sarah Stroud, Eastpointe
Trey Sutten, Cardinal
Victoria Whitt, Sandhills

Via Electronic Mail

Dear Chief Executive Officers,

The North Carolina Department of Health and Human Services is aggressively working to create flexibilities that will sustain and bolster our behavioral health and intellectual and developmental disability system during the COVID-19 emergency. We are working with federal, state and local partners to make as many regulatory, contractual, and service-definition modifications as needed to support service providers in doing their work – work that is more important than ever.

This letter outlines our efforts, which has been done in partnership with the LME/MCOs, providers, consumers, and other key stakeholders. Also, we outline the emergency flexibilities we are establishing for the LME/MCOs and providers to take advantage of in order to best face the evolving challenges. We want to be sure of the stability of our provider networks and that all our beneficiaries have uninterrupted access to care. The Department anticipates releasing further guidance to LME/MCOs and providers, as available.

Our objectives in this emergency are clear:

- To support the continuation of quality, medically necessary services and supports for consumers during this period of great change and uncertainty, recognizing the need for providers and consumers to rapidly adapt to new methods of treatment.

- To stabilize, sustain, and adapt provider networks to deliver services and supports tailored to the needs of North Carolinians in the face of the present challenge, while also readying providers for the potential lasting impact of this pandemic.

- To reduce, to the greatest extent possible, the need for any hospitalization, including facilitating discharge where appropriate and preventing avoidable readmissions from state psychiatric hospitals.

Below are the immediate measures we are putting into effect to bolster our work towards achieving the above-mentioned objectives:

Provide Flexible Funding for the COVID-19 Response

- Providing LME/MCOs authority to use up to 15% from their current risk-reserves for supporting providers who are accepting referrals, maintaining consumers in their existing residential placements, utilizing telehealth capabilities to the maximum extent possible, providing services that keep consumers from needing access to emergency departments and inpatient services and otherwise making efforts to deliver high quality services during this crisis, and to maintain the stability of the provider network and promote robust access to care throughout this pandemic situation, in accordance with criteria established by the LME/MCO.

- Authorizing LME/MCOs to use state single stream funds for responding to COVID-19 (e.g. by converting existing allocations to non-UCR and paying providers for telehealth services and supports) and authorizing immediate pay out of all remaining single stream monthly payments for the remaining state fiscal year.

- Authorizing the immediate release of $30 million of funds distributed among the LME/MCOs pursuant to S257, S.L. 2017-57, the Appropriations Act of 2018 for responding to COVID-19.

- Directing LME/MCOs to re-prioritize current spending plans of federal grant funds to support the COVID-19 response.

Maximize Flexibility to Stabilize Providers and Respond to the Changing Needs of Consumers

- Broadly expand of the allowable telehealth and telephonic services across service codes, types of providers, and methods of delivery. The policies will continue to be developed over the coming weeks with a retroactive effective date of 3/10/20. More information at: https://medicaid.ncdhhs.gov/about-us/coronavirus-disease-2019-covid-19-and-nc-medicaid

- Assume the U.S. HHS Office of Civil Rights will waive potential penalties for HIPAA violations against health care providers that serve patients through non-public facing communications technologies during the COVID-19 nationwide public health emergency. More information at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

- Follow SAMHSA guidance specific to 42 CFR Part 2 and the COVID-19 Public Health Emergency Response due to the increased need for SUD services to be provided telephonically. As per 42 CFR, in the event of a medical emergency, written consent requirements are waived; therefore, prohibitions on use and disclosure of patient identifying information would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists. More information here: https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf

- Increase flexibility for opioid treatment including take-home dosing with naloxone (where available) and initiating treatment via telehealth. More information at: https://www.samhsa.gov/medication-assisted-treatment

- Expedite the Medicaid in-lieu of services policy approval process to no more than 7 days to ensure LME/MCOs can tailor potential services needed in their region.

- Allow submission of state-funded alternative service definition requests and expediting approval process to no more than 7 days.

- Seek an approved Appendix K allowing for flexibility in our C Waiver programs. Submitted 1135 waiver to waive certain Medicaid requirements to maximize services and provider flexibilities, including provider screening and enrollment, certain Emergency Medical Treatment and Labor Act (EMTALA)

requirements, and waiving benefit authorization requirements. More information: https://medicaid.ncdhhs.gov/about-us/coronavirus-disease-2019-covid-19-and-nc-medicaid/covid-19-policy-flexibilities

- In collaboration with the Division of Health Service Regulation and the provider, work to allow flexibility in case of staffing shortages to achieve staffing ratios and active treatment requirements to meet the client's mental and physical health needs.
- Leverage the Department's flexibility to pause the collection of contractual penalties.
- Pause all state and Medicaid audits, settlements, and other oversight functions that do not impact consumer health and safety.
- Rapidly update clinical coverage policies to waive, to the to the fullest extent possible, all face-to-face provider requirements and similarly waiving all LME/MCO contract requirements that require face-to-face care coordination interventions.
- Rapidly pursue necessary temporary rule waivers to maximize flexibility in service provision.
- Communicate with county Departments of Social Services and Division of Juvenile Justice agencies about the reduction of access to child residential group home placement as well as the challenge for adults with IDD or SPMI (for whom DSS is guardian) rapidly entering some alternate home or residential setting due to federal guidance on social distancing/ risk in congregant settings.

Meanwhile, we have been working closely with LME/MCOs, which are eagerly working quickly to act and employ each and every possible strategy to stabilize their service networks and operationalize the changes outlined above. **We appreciate the LME/MCOs' collaboration and cooperation to date and ask that each LME/MCO will implement or continue the following actions:**

- Maintain clear and frequent communication channels with all providers, including communication of key Department flexibilities and responses to COVID-19.
- Support providers and LME/MCO care management/care coordination staff in proactively reaching out to beneficiaries, educating them about this event and our shared mission to support them through the event, including but not limited to adjusting crisis plans and PCPs to address services and support needs in a pandemic scenario to reduce risk of crisis triggering emergency care and additional burden to hospital system.
- Maintain members' Medicaid coverage and advise members of the stability of their coverage.
- Pause, to the greatest extent possible, all settlement and oversight functions, save those necessary to ensure consumer health and safety
- Waive prior authorization requirements within existing LME/MCO authority to be less restrictive than DHB, to the greatest extent possible if not already done, for medically necessary services needed for adequate response to the event Standardize to the greatest extent possible key modifications to policies and procedures across all LME/MCOs in an effort to ease adoption among providers.
- Allow for verbal agreements in lieu of written signatures in every instance when acting otherwise would prohibit continuation of service. Documentation shall include that the provider has received verbal consent/agreement from the member.
- Explore creation of bundled rates for providers, such as for opioid treatment providers, which will have to adapt their operations to support take-home dosing.
- Proactively monitor provider networks, identify potential or expected network gaps, on-board additional qualified providers as needed, and contract with out-of-network providers as needed to ensure access

to care

- Use available single stream funds and mental health block grant dollars to partner with local governments and Sheriffs to augment and supplement mental health services in jails and other settings, as permitted under CDC guidelines, to help stabilize the overall system.
- Partner with providers to help rapidly adjust their operations to adapt to the changing environment created by the necessary public-health measures and update their disaster plans to reflect the unique circumstances posed by COVID-19
- Identify additional opportunities for flexibility in LME/MCO provider networks, state policy modification and/or the public system-at-large and propose them to the State for immediate consideration.
- Follow SAMHSA guidance specific to 42 CFR Part 2 and the COVID-19 Public Health Emergency Response due to the increased need for SUD services to be provided telephonically. As per 42 CFR, in the event of a medical emergency, written consent requirements are waived; therefore, prohibitions on use and disclosure of patient identifying information would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists. More information here: . https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf
- Provide timely information to the State on the steps being taken in response to the above expectations.

The Department is working rapidly with the federal and state government to maximize support of these measures. With the fullest presumption of success, we ask LME/MCOs to begin work immediately organizing operational support to employ these measures so that implementation is not delayed.

Sincerely,

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Kody H. Kinsley
Deputy Secretary for Behavioral Health & IDD

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