Ohio | Department of Medicaid

Ohio | Department of Aging

NF-Based Level of Care Waivers, Specialized Recovery Services Program, MyCare Ohio & Medicaid Managed Care

Care/Case Management Emergency Protocol: Response to COVID-19

April 13, 2020

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On March 13th, 20th, 25th, 30th, and April 6th, the Department of Aging (ODA) and the Department of Medicaid (ODM) provided guidance to implement emergency protocols as part of the State's response to COVID-19. This document is a combination of the previous guidance and FAQ. The State expects this document to be shared with all appropriate staff.

The term Case Management Agency (CMA) refers to all of the following: PASSPORT Administrative Agencies (PAA), Ohio Home Care Waiver Agencies, Recovery Management Agencies, MyCare Ohio Plans and Managed Care Plans (as appropriate).

Please note, many of the protocols require emergency rule changes and are subject to approval from the Federal Centers for Medicare and Medicaid Services (CMS). If it is determined the changes implemented are not supported by CMS, the State will provide notification to discontinue the practice immediately and provide additional guidance. Please note, this is intended to be a living document and will be updated.

The PAAs serve individuals in multiple programs, if the PAAs are faced with a staffing shortage, staff may work across programs (e.g. case manager in Ohio Home Care, PASSPORT and MyCare) if they perform "like" functions. If this is to occur, the State must be aware and approve the time-limited activities.

When an action is taken, in which flexibility is permitted, case file documentation must clearly reflect the care/case manager's review of the individual's case, service needs, provider availability, back-up plan and emergency plan. Any activity authorized under this guidance must include the following statement at the beginning of each note: **AUTHORIZED BY THE STATE OF OHIO EMERGENCY PROTOCOL.**

Ohio Benefits Long-Term Services and Supports (OBLTSS)

AAAs and Non-AAA OBLTSS entities should suggest scheduling a telephonic assessment for individuals who walk-in and provide a set appointment when the individual can anticipate a call back from the OBLTSS entity. If a phone appointment is not feasible, the OBLTSS entity may provide the individual with a copy of the paper LTSSQ to complete and have returned to the OBLTSS entity.

County Department of Job and Family Services (CDJFS)

A. Individuals may apply for Medicaid in any of the following ways:
    1. Complete a paper application and mail it to the local CDJFS,
    2. Apply online at Medicaid.Ohio.gov, through the self-service portal, or
    3. Over the phone by calling 844-640-OHIO where an audio signature will be collected.

B. If an individual has barriers to obtaining, accessing or providing verification for resources and income, refer to MEPL 150https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/Elig-Chip/MEPL-150.pdf for further information. The CDJFS will process the application based on self-attestation.

C. ODM is currently in the process of reinstating Medicaid eligibility for recipients who were receiving Medicaid benefits on or after March 18, 2020. ODM will be reinstating Medicaid eligibility for any recipients who lost coverage effective 4/1/2020 or 5/1/2020 unless the individual voluntarily requested a discontinuance of eligibility, is no longer a resident of Ohio, or is deceased or if the individual was only approved on presumptive Medicaid or AEMA. If there are any issues, please inform the State regarding specific cases so that the State can have the individual reinstated. The MCPs/MCOPs received additional guidance on 4/2/2020.

Case Management/ Recovery Management Assessments

A. The State is allowing face to face requirements to be replaced with telephonic contact. If an assessment is unable to be completed telephonically within the required timeframes, the State is requesting the CMA to track the late assessments and submit to the State monthly. ODA does not require this report monthly. Only delayed initial assessments and reassessments should be included in this report. To minimize the use of individuals' personal minutes during telephonic assessments, the CMA should focus on obtaining the minimum information necessary to determine if the individual's needs are being met and if any case management interventions/authorizations are needed. Assessments must be validated at the next face to face visit. Assessment validation is defined as reviewing the assessment previously completed and updating or completing a new assessment based on the individual's needs. The subsequent validation of the telephonic assessment

does not change the initial approval or denial decision. If face to face validation occurs while the state is still under the COVID-19 state of emergency, and the individual does not appear to meet non-financial program eligibility requirements, the individual must remain on the program until the state of emergency is lifted and the individual can be reassessed.

B. If an individual is in an Assisted Living Facility, and the CM is not able to complete a phone assessment with the individual, the assessment should be documented as "late" and the assessment must be completed at the earliest date a face to face is feasible. Contact should continue with the AL facility staff to ensure all needs are met.

C. **Initial Level of Care Assessment**

1. A determination regarding non-financial eligibility criteria for program eligibility can be made if enough information is gathered through the telephonic comprehensive assessment and desk review. If the information is insufficient, the assessor must gather additional collateral information from other members of the individual's care team (e.g., physicians, family members, etc.) prior to issuing a determination. If the desk review and telephonic contact do not support enrollment, the agency must issue appeal rights. In-person validation of the assessment is not required. If the individual is determined to meet level of care and enrolled, the completed assessment must be validated at the next face to face visit.

2. The individual performing the assessment must obtain and document verbal approval of all paperwork necessary to complete a waiver enrollment. The documents must be completed with the individual's signature at the next available face to face meeting with the individual.

3. If the physician's office will not release information without a signed release, encourage the individual to contact the physician's office to determine if providing verbal permission is allowable so you may obtain personal information regarding the individual. If that is not possible, it may be necessary to mail/fax/scan the ROI to the individual and have them send a signed copy to the PAA.

4. If the assessor cannot obtain a physician's written certification of the level of care, please note OAC 5160-3-14(B)(3)(c)(i) permits the assessor to obtain verbal certification.

5. If verbal certification is not obtained without a release, the assessor must issue a level of care determination for the individual using the information available.

6. If approved, the assessor may proceed with enrolling the individual. If the individual does not meet the level of care requirement(s) for the program, the CMA must follow separate guidance related to adverse level of care determinations when the emergency protocol is activated. See http://codes.ohio.gov/oac/5160-3-14 for level of care process requirements.

7. If an individual cannot be reached for an initial assessment, please follow the CMA's internal process including documenting attempts including date, time, and method of outreach. Please note, enrollment criteria remains consistent. If a need is identified (regardless of the provider

capacity), please continue to enroll the individual as appropriate.

D. **Initial Assessment (including HRAs) without LOC determination (MCPs/MCOPs)**
The assessment can be completed telephonically. It must be validated at the next face to face visit as applicable.

E. **Annual Comprehensive Assessment (all CMAs)**
The assessment can be completed telephonically. It must be validated at the next face to face visit as applicable. For enrolled individuals who are unable to be reached, contact attempts must continue. If the CMA continues to be unable to reach an individual, the CMA should determine if escalating the case is necessary and follow internal escalation procedures which may include requesting a well-check visit from law enforcement. This option should be utilized only when deemed necessary.

F. **Adverse Level of Care Assessment**
All adverse LOC assessments may be conducted telephonically. A face to face LOC assessment is not required. If an initial assessment is completed telephonically and is recommended for denial, a telephonic adverse LOC should take place prior to issuing a denial and appeal rights.

If an annual assessment is completed telephonically and is recommended for potential disenrollment due to no longer meeting LOC criteria, no action will be taken until a face to face visit occurs following the conclusion of the emergency protocol period as determined by ODA. The AAA should track these cases so information can be validated at the next face to face contact.

G. **Specialized Recovery Supports Program Assessments**
The same protocol for LOC assessments and collection of supporting documentation and review may be applied to SRSP. There is no requirement for a physician's signature, but the individual is required to have an eligible ICD-10 code and ANSA for enrollment. This information can be verified telephonically until the medical records can be obtained or the next possible face to face visit.

H. **HOME Choice Assessments**
The State permits flexibility for Home Choices assessments to be completed telephonically. This process change is applicable to both the AAAs and Non-AAA OBLTSS entities and will only be in effect for the duration of the emergency protocol. Please contact HOME_Choice@Medicaid.Ohio.gov or call 1-888-221-1560 with questions. As of 3/24/20, Home Choice provided additional guidance ceasing transitions unless there are exceptional circumstances.

Contact Schedule

A. Face to face requirements should be replaced with telephonic contact. Regarding video conferencing, etc., unless superseded by guidance by the Office for Civil Rights (OCR) at the US Department of Health and Human Services (HHS), during this emergency CMA's shall continue to comply with all existing HIPAA regulations, applicable law, rules, policies, procedures, and contract terms and conditions to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI it creates, receives, maintains, or transmits on behalf of the State.

B. The Office for Civil Rights (OCR) recently announced that it will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency. See https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth- remote-communications-during-the-covid-19.html. If there are specific questions regarding HIPAA-related inquiries, please direct those questions to the CMA' internal legal/privacy/security officer.

C. For Assisted Living facilities, it is acceptable for the case manager to obtain necessary information from the AL staff for routine contacts if the individual is inaccessible via phone. The State suggests scheduling time with AL staff to discuss any updates on the status of multiple enrollees at a time. These contacts may be documented as in-person but will not be categorized as a reassessment. Please ensure documentation reflects the contact.

PAA- Specific Documentation:
For scheduled contacts required by the waivers, the visit type selected in PIMS must be in-person, even if the required contact/visit was completed through telephonic contact. This will allow the continued ability for ODA to pull reports directly from PIMS to measure compliance with contact requirements. The PAA must use the approved header in this guidance to clearly identify contacts made in accordance with the emergency protocols issued by ODA. Continue to label the contact type as initial or reassessment, quarterly visit, etc.

Service Provision

A. Please note, there have been no changes to the client liability processes at this time.

To clarify guidance provided on 3/13/2020, **all services** may be authorized or adjusted based on a telephonic assessment of need between the case manager and individual.

B. For any service that requires an in-person/environmental assessment, those meeting the threshold of a HSW risk may be authorized or adjusted based on telephonic assessment of need between care manager and individual. The individual and provider must be in agreement with the process required for service provision. If there is a service, such as pest control, that may require an individual to leave the home setting for service provider (NF respite stay), please consider available alternatives such as staying with an informal caregiver.

In terms of "threshold of HSW risk" the CM must consider if the individual may be unsafe within the current home. Examples of "unsafe" may include yet aren't limited to increased fall risk, inability to enter/exit his/her home or bites could lead to infections.

C. If services cannot be provided safely in the home, please complete a Health and Safety Action Plan and review the document with the individual telephonically. While disenrollment requests for health and safety are not being considered at this time, the HSAP should continue to outline the potential consequences. The CM should determine if the individual has ERS authorized and remind the individual on how and when to use the ERS device including routine testing. The CM should perform daily telephonic checks with the individual to determine how and if the

individual's health and welfare needs are being met.

The CMs should outreach to individuals to discuss current services and the individual's right to implement a backup plan and decrease in-person contacts with service providers. A decrease for any service authorizations is voluntary and should only be implemented due to the individual's choice. As Ohio continues to see increased cases of COVID-19, the State anticipates that provider capacity will decrease. Voluntary and temporary reductions in service authorizations may allow providers to be available for individuals. Case managers and providers must prioritize individuals with no natural supports in the home based. A Notice of Action would not be needed when the individual voluntarily requests a reduction in services since there is not adverse action taken by the CMA.

D. Participant Directed- All contacts required for enrollments are to be completed telephonically. Any enrollment scheduled to be done in-person will be completed telephonically. This includes enrollment with the Financial Management System.

E. Initial Service Plan Development-The State originally stated that services should only be authorized for 90 days per the 3/13/2020 guidance. The service plan may be authorized for up to 180 days or until the next face to face contact.

F. Ongoing Service Plan Monitoring and Authorization- Services for established individuals may be authorized for the duration of the service plan, as determined necessary by the case manager. If a new service is authorized as a result of telephonic contact with the individual, the new service may be authorized for up to 180 days or until the next face to face contact.

G. Transitions between Waivers- The receiving CMA must allow waiver services documented in the individual's service plan to continue.

ODM is permitting individuals enrolled on the Ohio Home Care waiver who reach their sixtieth birthday to remain enrolled on the waiver for the duration of the emergency. Individuals are to be disenrolled from the Ohio home care waiver at their next face-to-face assessment following the expiration of the emergency. The case manager's discharge planning responsibilities include assisting the individual with enrollment on another appropriate NF-level of care waiver. Individuals are to retain their level of care determination for the period it would have been effective in the Ohio home care waiver, absent a change of condition.

H. **Home Delivered Meals-** To ensure individuals have needed meals during the COVID-19 emergency, shelf stable/ blizzard meals may be authorized. The number of shelf stable/blizzard meals is dependent on the individual's needs. The State has not identified a minimum or maximum number of additional meals and authorization should be based on the assessed needs of the individual through the person-centered planning process.

Increased Home Delivered Meals ongoing may also be authorized. Per CMS guidance, CMAs cannot authorize more than two meals per day. Please consider the individual's storage capacity when authorizing, not the preference of the provider. The need for additional meals must be clearly documented, noting, ADDITIONAL MEALS AUTHORIZED BY STATE EMERGENCY PROTOCOL, as well as the type of meal ordered (frozen or shelf stable).

I. **Social Work Counseling**- The use of telephonic counseling is currently permitted for this service. The Board has recommendations and requirements on their website at: https://cswmft.ohio.gov/Whats-New, regarding services during the COVID-19 emergency.

J. **Service Verification**- For those services which may require a visit to validate completion or satisfaction (e.g., home modification), the CMA should use telephonic contact to approve completion. Validation must occur at next face to face. If bids are in process, it is the provider and individual's discretion as to proceeding with the service.

Incident Management/Health and Safety Assurance

A. The CM continues to be responsible for assuring health and safety in a timely manner regardless of reporting. The rationale for the tardiness must be documented in the incident narrative.

B. Care/Case Managers do not need to report COVID-19 through the IMS as its own incident. Please continue to follow the definitions and reporting requirements in Ohio Administrative Code (OAC) rule 5160-44-05 (Nursing facility-based level of care home, community-based services (HCBS) programs and specialized recovery services (SRS) program: incident management).

Please note that it may be appropriate to report the COVID-19 in the IMS if it is related to another existing incident reporting requirement, for instance: Reportable Incident "Hospitalization resulting in change to service plan" if the individual was hospitalized and then had a change in their service plan.

Hearings/Disenrollments

A. This guidance is applicable to both Medicaid funded HCBS and ODA's State-funded PASSPORT and Assisted Living programs.

1. Disenrollments will not be proposed unless the individual expires, requests disenrollment, moves out of state, transitions from State Funded to Medicaid funded AL or PASSPORT, or transitions between a Fee-for-Service waiver and the MyCare Waiver. This hold on disenrollments also applies to waiver enrollees receiving services in a nursing facility. PAA staff should refer to notice 0618286 for claims override instructions.

2. For those disenrollments currently being processed, the action should be rescinded unless the individual expires, requests a voluntary termination, or moves out of the state. The CMA should verbally provide an explanation to the individual and follow up with written communication. If written communication is not possible, documentation must reflect the conversation in the case record. If a hearing has already been scheduled, the CMA should notify the hearing officer the action has been rescinded. The individuals may choose to the cancel the hearing.

3. Transitions between the FFS waivers and MyCare waiver will continue.

Guidance for Individuals Suspected or Confirmed COVID-19

The following shall direct CMAs to assist individuals who are either symptomatic of (100- degree fever, cough, shortness of breath) being tested for, or have been diagnosed with COVID-19. ***If, at any time, the individual's physical needs require *immediate* attention to ensure health and welfare, contact 9-1-1 to triage the individual to the appropriate care setting.**

1. Instruct the individual to contact his/her primary care physician (PCP) if they have not already done so.

2. Assist the individual to prioritize essential service needs and identify additional backup options. This is to occur regardless if the individual has a paid provider assisting with service delivery or if the individual must rely on their backup plan for services.

3. Assess which essential services can continue, either as authorized/scheduled or via the backup plan. The case manager should assess whether the individual's health and safety can be assured in a home and community-based setting. Considerations for care at home include an evaluation of current level of potential or real exposure to COVID-19 and current level of need and whether needs can be met through formal/informal supports available.

4. Review with the individual his/her plan for medical attention.
    a. Assist with calls to physicians as needed to ensure the individual receives needed medical care.
    b. Verify adequacy of prescribed medication and other supplies.
    c. Develop plan(s) to obtain medication or other supplies in the event the individual is unable to obtain on his or her own.

5. Notify all providers (listed on the service plan) of the individual's status:
    a. Services which remain, or increase (including new service authorizations), must be communicated to the provider accordingly to ensure the provider takes needed precautions.
    b. If services are suspended due to engagement of back-up or emergency plan, providers must be informed.

6. Case Manager must monitor the individual's health status, in accordance with program contact schedules. All contacts will be documented in the individual's record.

7. If the individual cannot be safely maintained in a home and community-based setting, it may be necessary to explore alternative care settings. If the individual does not have a paid or informal provider/backup plan, or the individual is at high risk of spread to other members of the household and cannot be isolated appropriately, the case manager must review service needs and determine what alternate care setting is feasible for the individual.