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 Protocol

Response to COVID- 19 March 30, 2020

On March 13, 2020, 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 is a companion document to answer specific questions. All guidance and protocols must be forwarded and 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 periodically.

General:

1. **The State requests the activities performed under the Emergency Protocols be documented using consistent language. What language should be used?**
    a. Any activity authorized under this guidance must include the following statement at the beginning of each note:
    TELEPHONIC VISIT AUTHORIZED BY THE STATE OF OHIO EMERGENCY PROTOCOL.
    b. PAA- Specific Documentation:
        i. 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.
        ii. Continue to label the contact type as initial or reassessment, quarterly visit, etc.

2. **Is Skype/Face Time HIPAA compliant?**
    a. Unless superseded by guidance by the Office for Civil Rights (OCR) at the US Department of Health and Human Services (HHS), during this emergency CMA's shall continue to comply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

c. However, if you have specific questions regarding HIPAA-related inquiries, please direct those questions to the CMA's internal legal/privacy/security officer.

3. **If faced with a staffing shortage, can PAA staff work across programs (e.g. case manager in Ohio Home Care, PASSPORT and MyCare)?**
   a. Yes, staff may be permitted to work across programs if they perform "like" functions. If this is to occur, the State must be aware and approve the time-limited activities.

4. **Under the emergency protocol, how should HCBS disenrollments be handled?**
   a. This guidance is applicable to both Medicaid funded HCBS and ODA's State-funded PASSPORT and Assisted Living programs. 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 from a Fee-for-Service waiver to the MyCare Waiver (refer to Question #31).
   b. PAA- Specific Documentation:
      i. Refer to notice 0618286 for claims override instructions.

Assessments:

5. **How do we handle Long-Term Services and Supports (OBLTSS) walk-ins?**
   a. AAAs and Non-AAA OBLTSS entities may suggest scheduling a telephonic assessment with 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.

6. **What are the signature options for the 7200?**
   a. Individuals may apply in the following ways: 1) complete a paper application and mail it to the 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.

7. **If face to face assessments are replaced with telephonic contact, at initial enrollment how will the State collect the necessary signed releases of information? This information is needed to obtain physician records and validation of the LOC authorization.**
   a. 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.
   b. 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.
   c. 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. 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.

d. 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.

8. **If the assessor completes a level of care and issues an adverse level of care does the State require a face to face evaluation be scheduled?**
   a. If an initial assessment is completed telephonically and is recommended for denial, a face to face assessment should take place as soon as reasonably possible. Denial will not be entered into OB until the visit is completed, unless requested by the individual.
   b. 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.

9. **Are you able to share any information about Home Choice assessments and the face to face requirement? We know the CLS visit can be done by phone, but what about the Home Choice eligibility assessment?**
   a. 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.
   Home Choice provided additional guidance ceasing transitions unless there are exceptional circumstances.

10. **What do we do if we're unable to contact an individual?**
    a. For initial assessments on individuals who cannot be reached, please follow the CMA's current process. Document all attempts, including date, time, and method of outreach in the case notes.
    b. For enrolled individuals, contact attempts are to continue. The CMA will need to 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.

11. **Government issued phones have limited minutes. How do we minimize use of individual's minutes if we're expected to complete a full assessment telephonically?**
    a. 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. In these cases, the reassessment will be completed at the earliest date a face to face visit is feasible. The documentation of the phone contact will reflect the reason for the late reassessment, and it will be considered an excused delay.
    b. For initial assessments of individuals who have limited minutes, prioritize obtaining the information required to complete a level of care assessment. Reach out to family members, caregivers, and/or heath care providers, identified by the individual, who may be able to assist with additional necessary details.

12. **Many individuals at an AL facility do not have personal phones. How are we supposed to complete telephonic assessments and contacts if we have difficulty reaching the individual?**
    a. In this scenario, it is acceptable for the case manager to obtain necessary information from the AL staff for routine contacts. 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. Reassessments require the individual's participation at the earliest date a face to face visit is feasible. The documentation of the phone contact must reflect the reason for the late reassessment, and it will be considered an excused delay. Please note, the individual may not have a phone and can be contacted via conference call on facility phone. Please ensure documentation reflects the contact.

13. **Are telephonic assessments permitted for individuals transitioning from the community to NF?**
    a. Currently there is no requirement for a face to face assessment as most are done by desk review. Telephonic assessments may be completed.

14. **Those individuals at high risk require a visit. Those people are at most risk of infection so question the need for a face to face visit. Should a face to face visit be completed?**
    a. Assessments are not required to be required face to face. Face to face contact must be limited to the extent possible.

Service Provision:

15. **What are the expectations for transitions of care between HCBS waivers?**
    a. For individuals who may transition between CMAs, the receiving CMA must allow waiver services to continue as documented in the individual's service plan.

16. **Can case managers authorize additional meals?**
    a. To ensure individuals have needed meals during the COVID-19 emergency, 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). Per CMS guidance, CMAs cannot authorize more than two meals per day. If authorizing additional meals, please take into consideration the storage capacity of the individual, not the preference of the provider.

17. **Home Modifications: MyCare and OHCW requires a specification and verification visit. Will these visits be required?**
    a. If a home modification has been authorized (added to the service plan) the CMA can use telephonic contact to approve completion. Validation needs to 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.

18. **Is there a time limit on service plan authorizations made following a telephonic assessment?**
    a. For any enrollment completed as a result of a telephonic assessment, authorizations are limited to 90 days.

19. **New services, excluding home maintenance and chore services, home modification services and**

pest control services, may be authorized for up to 90 days or until the next face to face contact?

a. Services for established enrollees 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 90 days. At the next scheduled contact, the case manager may authorize the service for an additional 90 days.

20. **While the emergency protocol is activated, can a case manager authorize home maintenance and chore for pest control services to be provided?**

a. While the emergency protocol is activated, the home maintenance and chore service may not be authorized for newly enrolled individuals or enrolled individuals seeking the service.

Updated 3/27/2020

21. **SRS- There was a time that diagnoses were with application, is it possible when it is included, the diagnosis be included with the referral and used to avoid delay in processing?**
    a. The same protocol for LOC assessments and collection of supporting documentation and review may be applied to SRS. 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.

22. **For new assessments, will JFS waive the signature requirement for Medicaid applications?**
    a. Refer to Question #6

23. **Will JFS be flexible with Medicaid renewals since our consumers are high risk and may not be able to obtain verifications that are requested?**
    a. Pending CMS approval, renewals will be suspended for a period of 180 days.

24. **Individuals who are getting close to reaching their 90th day in the NF, are we still expected to disenroll on the 90th day?**
    a. Refer to Question #4.

25. **State Funded – will there be flexibility with the 90-day state funded cut off?**
    a. Refer to Question #4.

26. **If the assessor issues an adverse LOC for NF admissions, transfers or payer change, is a face to face adverse assessment required?**
    a. Adverse LOC assessments may be conducted telephonically or via other technology for NF admissions, transfers, and payer changes. A face to face LOC assessment is not required.

27. **Can the social work service authorized via waiver be provided telephonically?**
    a. The use of telephonic counseling is currently permitted. The Board has recommendations and requirements on their website at: https://cswmft.ohio.gov/Whats-New, regarding services during the COVID-19 emergency.

28. **If services cannot be provided safely in the home, what steps should the CM take?**
    a. If an individual's needs cannot be met in the home environment, please complete a Health and Safety Action Plan and review the document with the individual telephonically. While disenrollments 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.

29. **Should currently *proposed* disenrollments be processed?**
    a. 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.

30. **Can a disenrollment due to long term nursing facility placement continue to be processed per an individual's request?**
    a. Refer to Question #4.

31. **Will the monthly disenrollments from PASSPORT to MyCare continue to occur and will disenrollments/transitions from plan to plan continue to occur?**
    a. Transitions from PASSPORT (or Ohio Home Care Waiver) into MyCare will continue if an individual on a Fee for Service waiver becomes eligible for MyCare.

32. **Does the delay in signatures include Physician Verification Letter until the removal of emergency protocol?**
    a. Yes.

33. **The State requests the activities performed under the Emergency Protocols be documented using consistent language. What language should be used?**
    a. Refer to Question #1.

34. **Should contacts required for enrolling participant-directed providers occur telephonically?**
    a. Yes, 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 FMS as well. This question is also included on the Provider FAQ.

35. **What if a provider is short on staff and can only see a limited number of individuals in a day?**
    a. Providers must work with CMs and prioritize individuals with no natural supports in the home based on their needs (highest need to lowest) and case management direction. Provider staff should CMs aware of any provider shortages. For PASSPORT, please notify ODA as soon as possible at Provider_Network_Mgmt@age.ohio.gov; and please notify ODM via email at BureauNetworkManagement@medicaid.ohio.gov. This question is also included on the Provider FAQ.