Ohio | Department of Medicaid

Ohio | Department of Aging

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

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

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On March 13, 20, 25, 30, April 6, 13, 20, May 5, July 15, and September 18, the Ohio Department of Aging (ODA) and the Ohio 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 frequently asked questions (FAQ). The state expects this document to be shared with all appropriate staff. The protocols detailed within this document will remain in effect until the state provides a determination to resume normal operations. Transition planning for all protocols contained within this document will be communicated through updated versions of this document.

This protocol outlines modifications in assessment and case management practices throughout ODM and ODA programs. Modifications have been approved by the Centers for Medicare and Medicaid Services (CMS), through the state 1135 and 1915c waivers. https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

A companion document was developed for recipients of services and can be found at: https://medicaid.ohio.gov/Portals/0/COVID19/FFS%20-MCP%20Member-COVID-NOTICE-4-22-20.pdf.

Governor DeWine issued emergency amendments to Ohio Administrative Code (OAC) rules effective June 11 that incorporate emergency protocols previously issued into applicable OAC rules. This document has been updated with rule references associated with previous and newly issued protocol requirements. All emergency rules were originally effective from June 11 to Oct. 10. The practices outlined in this document are still effective due to the authorities granted in the 1915c (appendix K) and the 1115 waiver. All of the governor's orders can be found at: https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/

The term Case Management Agency (CMA) refers to the following: PASSPORT administrative agencies (PAA), Ohio home care waiver agencies, recovery management agencies, MyCare Ohio plans and

managed care plans (as appropriate).

Note that many of the protocols require emergency rule changes and are subject to approval from 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. 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 flexibility is permitted to address an action, 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."**

Individual Signature Requirements
Throughout the document, whenever an individual is required to provide his/her signature for program participation, the case manager should attempt to obtain an electronic signature. If capturing an electronic signature is not feasible, documents may be signed no later than then the next face-to-face visit.

173-40-02 PASSPORT program (state-funded component): individual eligibility requirements.

173-51-02 Assisted living program (state-funded component): eligibility requirements have been temporarily amended to allow ODA's designee to collect the individual's handwritten or electronic signature for agreement related to enrollment on a date later than the date the individual makes each agreement, but no later than the next reassessment of the individual.

173-42-03 PASSPORT program (Medicaid-funded component): enrollment and reassessment of individuals and **173-38-04** Assisted living program (Medicaid-funded component): enrollment and reassessment of individuals have been temporarily amended to allow ODA's designee to collect the individual handwritten or electronic signature regarding continued enrollment either at the time of reassessment or any time before the next reassessment.

5160-46-02 "Ohio Home Care Waiver Program: Eligibility and Enrollment" has been temporarily amended to permit an individual who is unable to sign their waiver agreement prior to waiver enrollment to submit an electronic signature or standard signature via regular mail, or otherwise in no instance any later than at the next face-to-face visit with the case manager.

5160-58-01 MyCare Ohio (Definitions): Revision to definition of "waiver service plan"
such that, if the member is unable to provide the signature at the time it is required, s/he may submit it electronically or via regular mail, or otherwise no later than at the time of the next face-to-face visit with the case manager.

5160-58-02.2 MyCare Ohio (Eligibility and Enrollment): Same signature relief as above but pertains to: 1) signing agreement to accept services in the community rather than in an institution; and 2) signature on acceptance of the care plan.

5160-58-03.2 (Member Choice, Control, Responsibilities, and Participant Direction): Same signature relief as above but pertains to signature on timesheet to verify services have been furnished.

Ohio Benefits Long-Term Services and Supports (OBLTSS)

Area Agencies on Aging (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 paper copy of the Long-Term Services and Supports Questionnaire (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.
    3. Over the phone by calling 844-640-OHIO (844-640-6446) 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 Medicaid Eligibility Procedure Letter No. 150 https://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 April 1, 2020, or May 1, 2020, unless the individual voluntarily requested a discontinuance of eligibility, is no longer a resident of Ohio, is deceased, or if the individual was only approved on presumptive Medicaid or Alien Emergency Medical Assistance (AEMA). If there are any issues, please inform the state regarding specific cases so that the state can have the individual reinstated. The MyCare Ohio plans and managed care plans received additional guidance on April 2, 2020.

Case Management/ Recovery Management Assessments

A. **173-42-03** PASSPORT program (Medicaid-funded component): enrollment and reassessment of individuals, and **173-38-03** Assisted Living program (Medicaid-funded component): enrollment and reassessment of individuals have been temporarily amended to allow face-to-face requirements to be replaced with telephonic or video 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 upon request. Only delayed initial assessments and reassessments should be tracked for potential submission to the state. This is not applicable to ODA.

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 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 assisted living facility staff to ensure all needs are met.

C. **Initial Level of Care (LOC) 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 to obtain personal information regarding the individual. If that is not possible, it may be necessary to mail/fax/scan the Release of Information (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)(a)** has been temporarily amended to permit the assessor to obtain an electronic signature for the physician certification. A physician certification must be obtained within thirty calendar days of submission of the 3697 or alternative form.

5. 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.

6. If an individual cannot be reached for an initial assessment, please follow and document the CMA's internal process and attempts including date, time, and method of outreach. Please note, enrollment criteria remain consistent. If a need is identified (regardless of the provider capacity), please continue to enroll the individual as appropriate.

7. For clarification, a level of care determination may be issued with the information available regardless if a release is obtained. A physician certification should be obtained within 30 days. If it is not obtained, ODM expects the CMA to continue seeking the certification, documenting the attempts in the individual's case file. At this time, the individual will not be disenrolled due to the prohibition while the emergency protocol is activated.

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 used only when necessary.

5160-46-02 "Ohio Home Care Waiver Program: Eligibility and Enrollment" has been temporarily amended to suspend the reassessment requirements during the emergency. Once enrolled on the Ohio home care waiver, an individual will not be disenrolled unless the individual requests disenrollment, moves out of state, transitions between the Ohio home care waiver and the MyCare Ohio waiver, or dies.

F. **Adverse Level of Care Assessment**

All adverse LOC assessments may be conducted telephonically. **5160-3-14** "Process and time frames for a level of care determination for nursing facility-based level of care programs" has been temporarily amended to allow adverse LOC determinations to occur by telephone, video conference, or desk review in lieu of a face-to-face. 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 Services 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 Choice 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.

Clarification was provided on April 22, 2020: the HOME Choice program has not ceased transitions. However, it is evaluating each essential transition for health, safety and community sustainability. When transitions can be conducted safely without risk to the member or community, they are approved.

I. **NEW: Long Term Care Consultations:**

1. **173-43-02** Long-term care consultation program: process and general standards for providing consultations and **173-43-03** Long-term consultation program: require consultations and exemptions have been temporarily amended to allow program administrators to offer and provide consultations by telephone, video conference, or in person.

2. **173-43-04** Long-term care consultation program: time frames have been temporarily amended to allow program administrators to provide consultations by telephone, video conference, or in person instead of exclusively through a face-to-face interaction. No modifications were applied to the timeframe requirement for this activity.

3. **173-43-05** Long-term care consultation program: staff certification has been temporarily amended to require any person who provides a long-term care consultation, rather than an *in-person* long-term care consultation, that includes an assessment of the individual's functional capabilities, fulfills any portion of a required Pre-Admission Screening and Resident Review determination, or fulfills any portion of a LOC review to have a current, valid license to be a registered nurse or social worker.

4. State Funded Enrollment: **173-40-02** PASSPORT Program (state-funded component): individual eligibly requirements and **173-51-02** Assisted living program (state-funded component): eligibility requirements have been temporarily amended and no longer prohibit the individual from enrolling into the programs if a previous enrollment occurred.

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.

   5160-45-01 "Ohio Department of Medicaid (ODM) -administered waiver program: definitions" has been temporarily amended to reflect that the face-to-face visit between an individual and a case manager may be conducted by telephone or electronically, unless the individual's needs require a face-to-face visit.

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. If there are specific questions regarding HIPAA-related inquiries, please direct those questions to the CMA's internal legal/privacy/security officer.

C. For Assisted Living (AL) 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 allows ODA to continue pulling 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.

B. To clarify guidance provided on March 13, 2020, **all services** may be authorized or adjusted based on a telephonic assessment of need between the case manager and individual. For any service that requires an in-person/environmental assessment, those meeting the threshold of a health, safety, and/or welfare (HSW) risk may be authorized or adjusted based on telephonic assessment of need between care manager and individual. The individual and provider must agree 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 has bites that could lead to infections.

C. If services cannot be provided safely in the home, please complete a Health and Safety Action Plan (HSAP) 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 an emergency response system (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, in this case, 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. A Notice of Action (NOA) would not be needed when the individual voluntarily requests a reduction in services since there is not adverse action taken by the CMA.

D. **Service Authorizations: Decreases and Terminations-** Services should only be provided if they are reflected in the person-centered service plan **and** based on an assessment of functional needs of the individual. An individual's person-centered service plan should be updated to reflect updated assessments of functional need. Services should not be provided that are not based on an assessed need. CMAs may decrease authorized services based on the assessed need of the individual. All proposals to decrease or terminate services authorizations require issuance of a NOA.

E. **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.

F. **Initial Service Plan Development-**The state originally stated that services should only be authorized for 90 days per the March 13, 2020, guidance. The service plan may be authorized for up to 180 days or until the next contact. The 180-day authorization may be renewed as needed.

   173-42-06 PASSPORT program (Medicaid-funded component): individual's choices and responsibilities has been temporarily amended to allow ODA's designee to meet the individual by telephone, video conference or in person to develop the individual's person-centered services plan.

G. **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. The 180-day authorizations may be renewed as needed.

173-42-06 PASSPORT program (Medicaid-funded component): individual's choices and responsibilities has been temporarily amended to allow ODA's designee to meet the individual by telephone, video conference or in person to develop the individual's PCSP.

5160-45-01 "Ohio Department of Medicaid (ODM) -administered waiver program: definitions" has been temporarily amended to reflect that the face-to-face visit between an individual and a case manager may be conducted by telephone or electronically, unless the individual's needs require a face-to-face visit.

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

ODM permits 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 Nursing Facility-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.

5160-46-02 "Ohio Home Care Waiver Program: Eligibility and Enrollment" has been temporarily amended to reflect that individuals enrolled on the Ohio Home Care Waiver who reach their 60 birthday will be disenrolled at their next face-to-face assessment following the expiration of the emergency.

I. **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 also may be authorized. Per CMS guidance, CMAs cannot authorize more than two meals per day. **173-39-02.14** ODA provider certification: home-delivered meals has been temporarily amended to allow the delivery of more than 14 meals in one delivery. 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).

J. **Social Work Counseling**- **173-39-02.12** ODA provider certification: social work counseling has been temporarily amended to allow telephonic or video counseling for this service. Providers must adhere to requirements set forth by the Ohio Counselor, Social Worker and Marriage and Family Therapist Board.

K. **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.

5160-44-26 (Community Transition Services), **5160-44-27** (Home Care Attendant Services), **5160-44-31** (ODM-administered Waiver Provider Conditions of Participation) and **5160-45-03** (ODM-administered Waivers: Individual Rights and Responsibilities) have been temporarily amended to reflect that individuals' signatures verifying waiver service delivery can be obtained electronically, via regular mail, or at the time of their next face-to-face visit with their provider.

L. **PASSPORT Homemaker Service:** The service definition for **173-39-02.8** ODA provider certification: homemaker has been temporarily amended to include errands outside of the presence of the individual that is needed by the individual to maintain the individual's health and safety (e.g., picking up a prescription or groceries for the individual).

M. **PASSPORT Personal Care Service:** The service definition for **173-39-02.11** ODA provider certification: personal care has been temporarily amended to include errands outside of the presence of the individual that is needed by the individual to maintain the individual's health and safety (e.g., picking up a prescription or groceries for the individual).

N. **PASSPORT Non-medical Transportation:** The service definition for **173-39-02.18** ODA provider certification: non-medical transportation has been temporarily amended to include errands outside of the presence of the individual that is needed by the individual to maintain the individual's health and safety (e.g., picking up a prescription or groceries for the individual).

O. **PASSPORT Scheduling Personal Care Aides and Participant-Directed Providers: 173-39-02.21** ODA provider certification: scheduling personal care aides and participant-directed providers has been temporarily rescinded. Rescission of this rule allows the care manager to authorize services by a participant-directed provider to exceed five individuals per week, forty hours per week for an individual and fifty-six hours per week for all individuals served. Authorization of services beyond the parameters of the rescinded program rule must be based on the need of the individual assessed and service authorization must be reflected in the PCSP.

P. **Legally Responsible Family Member as Service Provider Option:** Updates have been made to allow certain legally responsible family members to become paid service providers for certain waiver services. Please refer to (https://medicaid.test.ohio.gov/Portals/0/COVID19/Expanding-Direct-Care-Workforce-Agency-Providers.pdf, https://medicaid.ohio.gov/Portals/0/COVID19/Expanding-Direct-Care-Workforce-Participant-Directed.pdf) for detailed guidance related to these temporary changes.

Q. **Adult Day Services (ADS):** Updates have been made to allow ADS to be provided both telephonically and within the home. Please refer to **(**https://medicaid.ohio.gov/Portals/0/COVID19/ADS_EO_Implementation_In-

HomeTelephonic_070120.pdf) for detailed guidance related to these temporary changes.

In accordance with the August 31 Director's Order on the Opening of ADS and Senior Centers, all ADS facilities and senior centers serving older Ohioans are permitted to reopen so long as all safety standards are met as outlined in the order. Companion guidance documents for all Senior and Adult Day Centers can be located here. Additional reopening guidance including frequently asked questions (FAQ) and testing can be found here. Services may resume as early as September 21, 2020.

The CMAs is to work with individuals seeking ADS as outlined in guidance on the ODA website found here or ODM's website here, including new service authorizations. *Note – both guidance documents are identical.

Incident Management/Health and Safety Assurance

A. Although face-to-face visit requirements **may** be replaced with telephonic contact, the protocol allows the flexibility for face-to-face visits to occur, if determined necessary by the CMA.

   The CMA remains responsible for the health and safety of enrolled individuals, coordinating and implementing the interventions necessary to mitigate identified risks. The CMA may determine a face-to-face visit is necessary for this purpose. If determined necessary, the CMA must ensure adherence to CDC and State of Ohio guidelines and/or regulations. This includes, but is not limited to, the number of staff visiting any setting, provision of appropriate PPE, etc.

   The Home Visiting Guidance https://medicaid.ohio.gov/Portals/0/COVID19/Home-Care-A-Guide-for-Face-to-Face-Visits-During-COVID.pdf and LTSS Pre-Surge Planning Toolkit https://medicaid.ohio.gov/Portals/0/COVID19/LTSS_TOOLKIT_FINAL_6_19_20.pdf should be utilized to guide all visits deemed necessary in a private residential setting. The Home Visiting Guidance was developed in collaboration with the Department of Aging, Department of Developmental Disabilities, Department of Health, Department of Medicaid and Commission on Minority Health. This guidance provides a list of questions to ask individuals prior to a home visit, preparation guidelines, and information cleaning/sanitizing during and between visits.

   Due to the recent increase in COVID-19 cases throughout the state, as well as ODH/ODA requirements for routine COVID-19 testing, introduction of CMA visitors in these settings may introduce additional risk of exposure to staff and residents within the facility. CMA staff are strongly encouraged to establish open and ongoing communication with facility staff to ensure individuals needs are being met. As a reminder, the Long-Term Care Ombudsman are essential to assuring protection of resident rights and assisting individuals with any questions or concerns about their rights, care and communication needs. Please follow your routine process for referrals to the individual's local Ombudsman agency.

B. 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.

C. 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 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.

D. Health and Safety Action Plans (HSAPs) are to continue to be initiated and monitored, in a manner consistent with training provided by ODM and ODA. HSAP completion is appropriate in circumstances in which an individual is identified to voluntarily place themselves in jeopardy. Although there are required components of the Health and Safety Action Plan, each HSAP is created in a way that is person-centered and reflects the needs of each individual. The HSAP is to serve as a tool to facilitate conversation with the individual, ultimately resulting in the individual making an informed choice about their desired action plan.

   The HSAP is not intended to serve as a general reminder of safety practices, but rather focused on potentially risky behaviors. Resumption or initiation of any specific service, ADS participation, for example, should result in general COVID-19 precautionary education being provided to individuals. Initiation of an HSAP is only appropriate if there are specific risks identified with individualized interventions developed to mitigate that risk.

   Although signature requirements are suspended for the duration of the emergency period, all HSAPs developed and/or updated should be mailed to the individual.

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, establishes residence out of state, transitions from state funded to Medicaid funded Assisted Living 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.

      173-40-02 PASSPORT program (state-funded component): individual eligibility requirements and **173-51-02** Assisted living program (state-funded component): eligibility requirements have been temporarily amended to allow ODA's director to approve an extension to the 90-day limit on enrollment in the state funded components of the PASSPORT and Assisted Living programs.

      5160-46-02 "Ohio Home Care Waiver Program: Eligibility and Enrollment" has been temporarily amended to reflect that waiver participants who lose Medicaid or waiver eligibility will not be

disenrolled from their waiver, unless the individual requests disenrollment, moves out of state, transitions between their current waiver and the MyCare Ohio Waiver, or dies.

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.

   Transitions between the Fee for Service (FFS) waivers and MyCare waivers will continue. Please note: Individuals turning 60 and eligible for the PASSPORT program may choose to voluntarily disenroll from Ohio Home Care and enroll onto PASSPORT

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 the individual relies 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.