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

July 21, 2021

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On March 13, 20, 25, 30, April 6, 13, 20, May 5, July 15, September 18, November 25th, and May 14th 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.

Since the most recent issuance of the Care/Case Management Emergency Protocol, applicable Ohio Administrative Code (OAC) rules have been updated to reflect ongoing eligibility, provider certification, and service rule changes for each program. This updated document eliminates duplicative or changed guidance. Case Management Agencies are expected to review and implement practices as outlined in the OAC rules and follow typical processes (e.g., reporting incidents, etc.) unless otherwise discussed in this protocol. As the Public Health Emergency status, CMS, CDC and ODH guidelines evolve and impact protocol activities, this protocol will be updated to include transition planning activities.

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).

Assessment & Contact Schedule

As vaccines have become available, ODM and ODA anticipate in-person visits to resume in a phased approach with the goal for all individuals to have an in-person visit/assessment completed no later than six months after the Federal Public Health Emergency ends. Each CMA is expected to submit a completed transition plan to resume in-person visits to their respective oversight agency (ODA or ODM). For ODA administered waivers, the PAAs should submit their transition plan to ODAHCBSCareManagement@age.ohio.gov for review and acceptance. For ODM-administered programs, the CMAs should submit their transition plan to their above-listed contact for review and acceptance. The transition plan must include timeframes, staffing capabilities, and prioritization strategies. When determining scheduling needs for individual caseloads, CMAs should consider prioritizing individuals with

intense needs (e.g., higher risk stratification), health and safety concerns and individuals enrolled during or after March 2020. The transition plan should include Phase One beginning no later than 9/15/21, with Phase 2 beginning at the conclusion of the Federal Public Health Emergency.

For example:

- **Phase One beginning no later than 9/15/21**
  - New Enrollees:
    - **LOC Assessment:** in-person
    - **ANSA Assessment:** in-person
    - **Initial CM Assessment**: in-person
    - **Contact Visits**: Offer in-person as staffing allows
  - Existing Enrollees
    - **Annual LOC Assessment (MyCare)**: in-person
    - **ANSA Assessment**: in-person
    - **Individual newly enrolled post March 2020 (has not had an in-person visit)**: in-person
    - **Annual Reassessment**: in-person as staffing allows
    - **Significant Change Event**: in-person as staffing allows
    - **Contact Visits**: in-person as staffing allows

- **Phase Two beginning once Federal Health Emergency ends**
  - All Enrollees: visits and assessments to resume in-person

Upon outreach, if an individual refuses an in-person visit in his/her residence, additional options (video conferencing, outdoor visits, etc.) should continue to be explored. If an individual continues to refuse all options, the CM should document the reason in the clinical record and continue with a telephonic contact. An in-person visit will not be mandated until the Federal Public Health Emergency concludes. The need for health and safety in-person visits must be evaluated and conducted on a case-by-case basis as deemed appropriate. Visits for children under the age of 12 years old should be evaluated on a case-by-case basis due to this population's current ineligibility of COVID-19 vaccines.

When the CMA conducts a face-to face visit, the CMA must ensure adherence to CDC, https://www.cdc.gov/, State of Ohio guidelines, and/or ODH visitation regulations for Nursing and Residential Care facilities. This includes, but is not limited to, the number of staff visiting any setting, provision of appropriate PPE, etc.

For those activities in Phase 1, when a face to face visit is not completed, continue to follow the guidance below.

A. If a telephonic or video contact LOC assessment results in an adverse determination, a face-to-face assessment must be completed to verify the determination in accordance with OAC 5160-3-14.

B. 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 CMAs 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.

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

C. 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 means reviewing the assessment previously completed and updating or completing a new assessment based on the individual's needs.

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

E. Whenever an individual is required to provide his/her signature, 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 the next face-to-face visit.

F. **PAA- Specific Documentation:**
For scheduled contacts required by the waivers, the visit type selected in PIMS must be categorized as in-person even if the required contact/visit was completed through telephonic contact. 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.

G. **Initial Level of Care (LOC) Waiver Assessment**

1. If the individual is determined to meet LOC and enrolled based on an allowable telephonic assessment, the completed assessment must be validated at the next face-to-face visit as described in *Assessment & Contact Schedules Paragraph A*.

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.

Service Authorizations

A. **Service Authorization Timeframes:** All services may be authorized or adjusted based on a telephonic assessment of need between the case manager and individual. The length of service authorization should reflect the assessed need.

B. **Service Verification:** For those services which may require a visit to validate completion or satisfaction (e.g., home modification), the CMA may 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.

C. **Scheduling Personal Care Aides and Participant-Directed Providers: 173-39-02.21:** ODA Provider Certification: Scheduling personal care aides and participant-directed providers is active again and the language in the rule remains unchanged in permanent rule. Previous rescission of this rule allowed 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. Flexibilities allowed while this rule was temporarily rescinded are no longer active. Please note: 173-39-02.21 (B)(2) continues to allow an emergency exception, as described in the rule.

D. **Legally Responsible Family Member as Service Provider Option**: Refer to OAC Chapters 173-39 (ODA certified providers) and OAC Rule 5160-44-22 for waiver nursing and OAC Rule 5160-46-04 (A) for personal care aide services for guidance.

E. **Adult Day Services (ADS):** Updates were made to allow ADS to be provided both telephonically and within the home. Please refer here for detailed guidance related to these temporary changes. 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.

The CMA 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.

Health and Safety Assurance/ Incident Management

A. 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, https://www.cdc.gov/, State of Ohio guidelines, and/or ODH visitation regulations for Nursing and Residential Care facilities. This includes, but is not limited to, the number of staff visiting any setting, provision of appropriate PPE, etc.

B. 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.

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.**

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

B. 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.

C. 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.

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

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

F. 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.

G. 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.

Disenrollments

This guidance is applicable to Medicaid-funded HCBS NF-based LOC waivers. ODA's State-funded PASSPORT and Assisted Living programs will be provided with guidance on disenrollment protocol via ODA Notice. Disenrollment allowances for each program are in accordance with the following:

A. **PASSPORT**: OAC 5160-31-03 Eligibility for enrollment in the PASSPORT HCBS waiver program

B. **Assisted Living**: OAC 5160-33-03 Eligibility for the Medicaid-funded component of the assisted living program

C. **Ohio Home Care Waiver**: OAC 5160-46-02 Ohio home care waiver program: eligibility and enrollment

D. **MyCare Waiver:** May resume disenrollments in accordance with MEPL-150B https://medicaid.ohio.gov/static/About+Us/PoliciesGuidelines/MEPL/MEPL-150B.pdf

E. **SRSP**: May resume disenrollments in accordance with MEPL-150B https://medicaid.ohio.gov/static/About+Us/PoliciesGuidelines/MEPL/MEPL-150B.pdf