

**NF-Based Level of Care Waivers, Specialized Recovery Services Program,  
MyCare Ohio & Medicaid Managed Care Care/Case Management Protocol  
Response to COVID-19 March 25, 2020**

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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.

**1. Initial Assessment with LOC determination**

- The State will permit flexibility with required timelines. A list of "late" assessments must be provided monthly during the established timeframe in which flexibility has been granted by the State.
- The State will allow the face to face assessment requirement to be replaced with telephonic contact. When enough information is gathered through a telephonic comprehensive assessment and desk review, a determination regarding non-financial eligibility criteria for program enrollment will be made. If the information collected via telephone 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.
- The assessment must be validated at the next face to face visit.

**2. Initial Assessment without LOC determination**

- The State will permit flexibility with required timelines. A list of "late" assessments must be provided monthly during the established timeframe in which flexibility has been granted by the State.
- The State will allow the face to face assessment requirement to be replaced with telephonic contact. The assessment must be validated at the next face to face visit.

**3. Annual Comprehensive Assessment**

- The State will permit flexibility with required timelines. A list of "late" assessments must be provided monthly during the established timeframe in which flexibility has been granted by the State.

- The State will allow the face to face assessment requirement to be replaced with telephonic contact.
- The assessment must be validated at the next face to face visit.

**4. Assessment based on significant event**

- The State will permit flexibility with required timelines.
- The State will allow the face to face assessment requirement to be replaced with telephonic contact.

**5. Contact Schedules**

- Face to face requirements may be replaced with telephonic contact. The case/care management agency must prioritize individuals at the highest risk levels for face to face visits.

**6. Initial Service Plan Development**

- Service authorizations and adjustments may be made based on telephonic assessment of need. All services may be authorized telephonically with the exception of the following: home maintenance and chore services, home modification services and pest control services.
- The service plan will be authorized for up to 90 days or until the next face to face contact.

**7. Ongoing Service Plan Monitoring and Authorization**

- Service authorizations may be adjusted to decrease in-person contact. Service authorizations and adjustments may be made based on telephonic assessment of need. Existing service authorizations may be extended via telephonic contact. New services, excluding those services listed in #6, may be authorized for up to 90 days or until the next face to face contact.
- Authorization of Home Delivered Meals – CMs may authorize additional shelf stable and frozen meals per the individual’s assessed needs.

**8. Incident Management/Health and Safety Assurance**

- 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.
- 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.

## March 25, 2020- Update – Guidance for Individuals Suspected or Confirmed COVID-19

As additional cases of COVID-19 are confirmed in the State of Ohio, preventative measures are being implemented which may require individuals and providers to self-quarantine. An increase in the number of direct care providers unable to continue to provide care will directly impact service delivery.

To proactively anticipate and minimize the potential of negative health and safety outcomes to individuals, case managers are directed to facilitate service authorization conversations with all enrolled individuals with the goal of both meeting the individual's needs and minimizing in person contact through essential service planning, and implementing back-up and emergency plans.

Effective immediately, to minimize contact, case managers shall contact individuals authorized to receive Personal Care, Consumer Directed Personal Care, Homemaker, Home Care Attendant and Choices Home Care Attendant services to evaluate the current service level and determine if a decrease in frequency and/or duration of these services is feasible. If the individual is in agreement, service authorizations may be decreased temporarily. If those services are decreased, the case manager shall determine if additional service authorizations, such as home delivered meals, would be beneficial to meet needs. The State will permit flexibility with payor sequencing requirements based on the need to meet individual's immediate health and safety needs. Waiver services should not be used to supplant informal supports, unless informal supports are not viable due to the COVID-19 pandemic.

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.