Ohio Department of Aging | Ohio Department of Health | Ohio Department of Developmental Disabilities | Ohio Department of Medicaid

Next Steps for COVID-19 Response: NF/AL-LTC Facilities/ICF-IDD

Tuesday, April 7, 12-2 PM

Agenda

1. **Introductions**

2. **Documents that address hospital and nursing facility admission, transfer, and discharge**
   - ODH COVID-19 Discontinuing Transmission-Based Precautions
   - Transfer and Discharge Checklists
   - Health Care Isolation Center Plan DRAFT

3. **Response to stakeholder feedback received to date**
   - Ohio Agencies' Consideration of OHCA/LAO 1135 Waiver Requests DRAFT

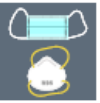
4. **PPE data and survey:** https://www.surveymonkey.com/r/88R2KSD

5. **Quick COVID-related updates**
   - ODA/ODH/DODD/ODM Toolkit Launch Last Friday
   - ODM Managed Care Provider Agreement Updates
   - ODM Telehealth Updates for LTSS Providers
   - ODA/ODM guidance document + companion case management document

Introduction to Key Terms & Concepts

Personal Protective Equipment (PPE)

This toolkit includes guidance, strategies, and options to optimize supplies of PPE while minimizing the spread of COVID-19 and protecting health care personnel and other staff. Optimizing the use of PPE is critical during this phase of "pre-surge planning" as we prepare for an increase in the number of people who are COVID-19 positive (+).

PPE TYPE	CONVENTIONAL CAPACITY	CONTINGENCY CAPACITY	CRISIS CAPACITY
MASK 	Under normal circumstances, provide patient care using infection prevention and control without any change in daily practices. PPE should be used according to product labeling and local, state, and federal requirements.	During periods of expected PPE shortages, take action to change daily standard practices (cancel elective and non-urgent procedures) to reduce the use of PPE. Shift PPE supplies from disposable to re-usable, implement extended wear, and ensure appropriate cleaning and disinfection.	During periods of known PPE shortages, use additional conservation measures, including PPE use that does not correspond with U.S. standards of care. In addition to the contingency strategies (extended use and re-use), also use PPE beyond the manufacturer-designated shelf life, prioritize the use of PPE for selected activities, and use alternative items that have not been evaluated as effective.
EYE PROTECTION 			
GOWN 			
GLOVES 			

Patient/Resident COVID-19 Status

One of the most important things we can do during this public health crisis is to identify and physically separate individuals based on their exposure to and contraction of COVID-19. This action is necessary to prevent the spread of the infection to both patients/residents and health care personnel. With this in mind, patients/residents should be divided into the following three status categories: no exposure, exposed, and COVID-19 +.

No Exposure
No Symptoms

Many residents appear well and are able to receive care as they would under usual circumstances. Even with these individuals, staff should create a culture of safety and practice vigilant sanitation and cleaning (e.g. frequent handwashing, daily sanitation) and staff interacting with non-exposed patients/residents should wear facemasks.

Exposed
No Symptoms

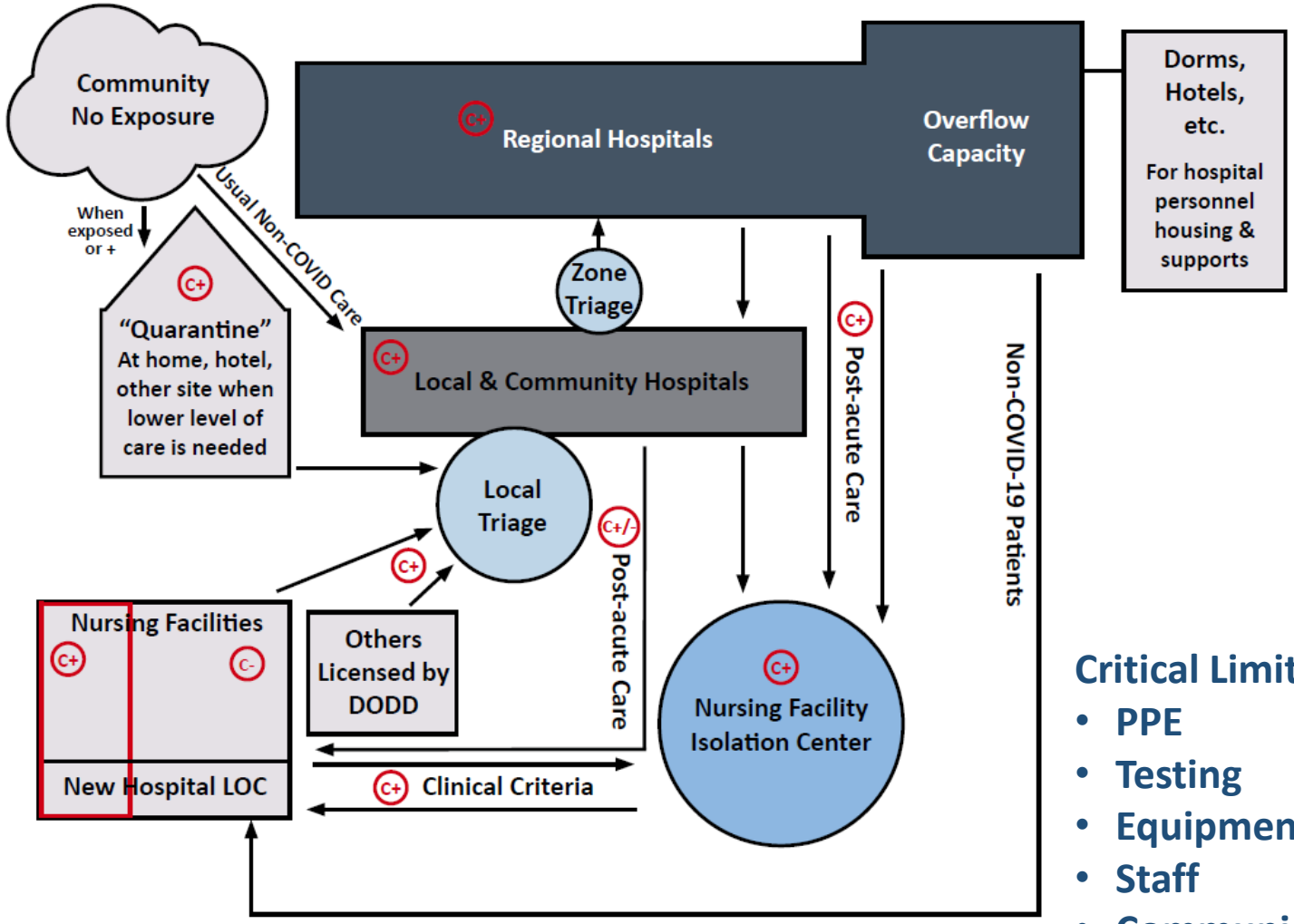
A subset of patients/residents will be been notified by the local health district and/or will have known direct contact for an extended period of time with someone who has contracted COVID-19. These individuals require careful monitoring for a 14 day period, and additional PPE should be used when interacting with people in this status.

COVID-19 +
Confirmed or Suspected

At this point in the pandemic, all people who have respiratory symptoms and those who have tested positive for the illness should be carefully assessed and monitored for escalating symptoms. We realize that this categorization is not perfect, as the CDC recently acknowledged that people who have COVID-19 are infectious 2 days before symptoms appear. With an abundance of caution, we recommend additional required PPE when working with these individuals, as outlined in this document.

PRE-SURGE PLANNING

Ohio's COVID-19 Health Care Delivery System



4/3/20

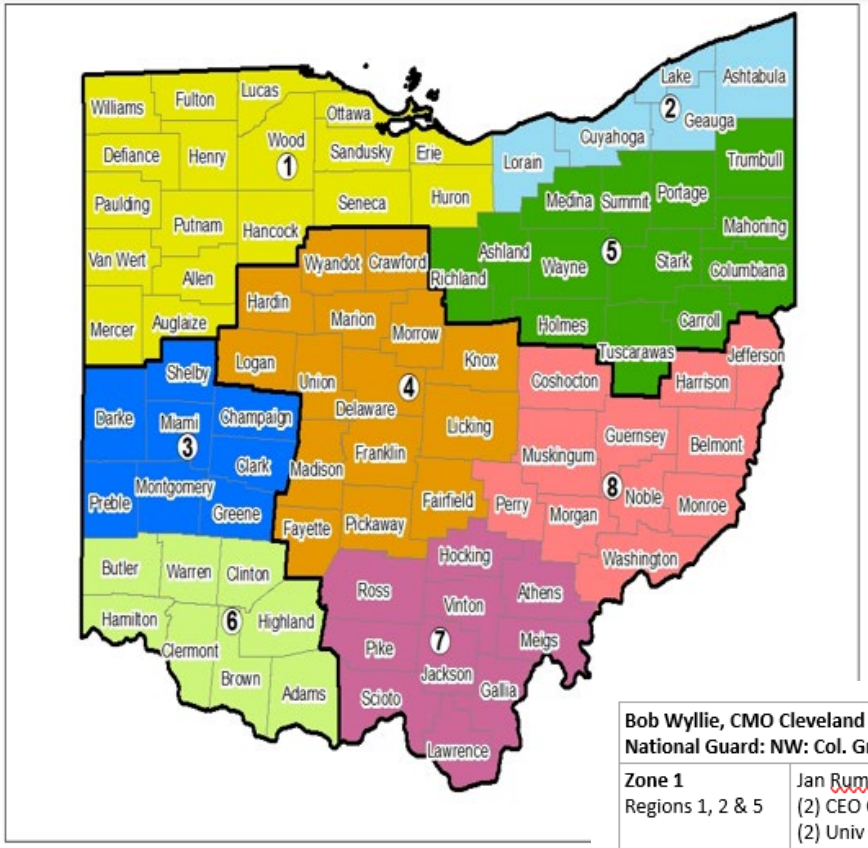
Critical Limiting Factors:

- PPE
- Testing
- Equipment
- Staff
- Communication
- Transportation

MIKE DEWINE
GOVERNOR OF OHIO

Ohio Department of Health

Ohio COVID-19 Region Map



Bob Wyllie, CMO Cleveland Clinic **National Guard: NW: Col. Gregg Biddle & NE: Col. James McCandless**		
Zone 1 Regions 1, 2 & 5	Jan Ruma, VP HCNO (2) CEO Cleve Clinic (2) Univ Hosp (3) Summa (1) Regional Mercy	(1) ProMedica (5) Aultman (2) MetroHealth (5) Akron Childrens
Andy Thomas, CMO, OSU **National Guard: Central: Col. Charlie Buchanan**		
Zone 2 Regions 4, 7 & 8	(7) Holzer Health (7) Adena Health (4) Trinity, Mt. Carmel (4) OhioHealth	(4) Nationwide Childrens (4) OhioHealth
Rick Lofgren (UC Health, CEO) **National Guard Southwest: Col. Bryan Moore & Southeast: Col. Gerry Clark**		
Zone 3 Regions 3 & 6	(3) Premier Health (6) TriHealth (3) Dayton Children's (3) Cincinnati Children's (3) GDAHA	(3) Kettering (6) Christ Hospital (6) Bon Secours Mercy

Clinical Resource Team: Bridget Harrison, Gov. DeWine's Office,
Maureen Corcoran, Director Medicaid *4-1-20 Updated*

Statewide & Local Workplan
Hospital-NF/Facility Local/Community Coalitions

1. Macro-Statewide Strategies:
   - » PPE
   - » Testing
   - » Vents

   } SURVEY

   - » Transportation
   - » Standardize hospital-facility clinical protocols: Transfer & Discharge

2. Hospital-NF/Facility-Local Health Department Zones
   - » Develop Hospital-NF/facility-Local Health Department Clinical Coalition
     - Includes clinical support and hotline/communication
   - » Assess physical plant changes needed- cohorting and separate, dedicated isolation center. Inc. options for individuals who may wish and be able to go home with supports.
   - » Connect/build out strategies with community providers and services
   - » Need a communication strategy, inc. rollout to all NF/facilities etc.

COVID-19 Discontinuing Transmission-Based Precautions

Discontinuing Transmission Based Precautions

- When discharging most individuals to a non-congregate care setting, utilize the CDC non-test-based criteria to establish the release from transmission-based precautions (isolation). These criteria include:
  - 7 days since onset of symptoms, and
  - 3 days with no fever without use of fever-reducing medication, AND
  - 3 days of stable and improved respiratory status

- In congregate living situations (such as nursing facilities) and with individuals who are hospitalized or severely immunocompromised, criteria for release from isolation criteria include:
  - 14 days since onset of symptoms AND
  - 3 days with no fever without fever-reducing medication AND
  - 3 days of stable and improved respiratory status.

Discontinuing Transmission Based Precautions, Cont'd

- Ultimately, clinician judgment is required to determine release from transmission-based precautions. Treating clinicians may determine that a test-based strategy is necessary in very specific clinical situations.

- For patients being released from hospitals, discharge planning and discharge documentation should include date of onset of symptoms, isolation status, and need for continued transmission based precautions, clearly establishing that the receiving facility has the ability to meet infection control requirements.

Transfer and Discharge Checklists

TOOL 6: Patient/Resident Transfer Checklist

Clinical Criteria for Transferring Facility Residents to Hospitals During Pandemic

This checklist is intended to assist with communications when transferring COVID-19 residents to a hospital. It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. Please check all that apply.

	KEY CRITERIA FOR TRANSFER OF COVID-19 RESIDENT	
☐	COVID-19+ status ☐ Confirmed (tested positive)~~Presumed~~ ☐ Probable ~~Tested~~	
☐	Advanced directive exists, designates desire for level of care at hospital	
☐	Patient is level 3 or 4 severity or NEWS score over 5	
	VITALS	
☐	Temp (F)	< 95° or > 100~~104~~°
☐	SBP (mmHg)	< 90 or > 180
☐	HR (per/min)	< 50 or > 110
☐	RR (per/min)	< 14 or > 22
☐	Pulse ox %_____ on _____%FIO2, or ___L/nc	
☐	Unable to maintain O2 sats > 90% on 40% FiO2	
☐	Vital Signs	Change of >25% of baseline
	ADDITIONAL CONSIDERATIONS	
☐	Dyspnea cannot be managed despite medications and oxygen	
☐	Evidence of organ dysfunction (angina, kidney failure)	
☐	Other	
	OTHER CLINICAL INFORMATION	
☐	Patient Medical ID/wristband	
☐	Diagnoses	
☐	Medications	
☐	Allergies	
	COMMUNICATIONS	

TOOL 6-A: Patient/Resident Transfer to Health Care Isolation Center Checklist

Clinical Criteria for Transferring Patients/Residents to Health Care Isolation Centers (HCIC) During Pandemic

This checklist is intended to assist with communications when transferring COVID-19 residents to a health care isolation center (HCIC). It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. Please check all that apply.

	KEY CRITERIA FOR TRANSFER OF COVID-19 RESIDENT	
☐	COVID-19+ status ☐ Confirmed (tested positive) ☐ Probable	
☐	Advanced directive exists, designates desire for level of care at HCIC	
☐	Patient is level 2 or 3 severity or NEWS score over 5. If level 2, detail the reason for transfer below (note: clinically stable COIVD-19 + patients/residents are not candidates for admission to an HCIC) _____ _____	
	VITALS	
☐	Temp (F)	< 95° or > 100°
☐	SBP (mmHg)	< 90 or > 180
☐	HR (per/min)	< 50 or > 110
☐	RR (per/min)	< 14 or > 22
☐	Pulse ox %_____ on _____%FIO2, or ___L/nc	
☐	Unable to maintain O2 sat > 90% on 40% FiO2	
☐	Vital Signs	Change of >25% of baseline
	ADDITIONAL CONSIDERATIONS FOR HOSPITAL LEVEL OF CARE	
☐	Dyspnea cannot be managed despite medications and oxygen	
☐	Evidence of organ dysfunction (angina, kidney failure)	
☐	Other	
	OTHER CLINICAL INFORMATION	

TOOL 7: Hospital Discharge Criteria Checklist to Facility/Home – REVISED 4/6/20

The hospital discharge of an individual with COVID-19 to home or long-term services facility should be made in consultation with the individual's clinical care team, and local or state public health departments, as appropriate.

This checklist is intended to assist with communications when discharging COVID-19 residents from a hospital. It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. Please check all that apply.

VERIFY RESIDENT CONTACT INFORMATION	
☐	Obtain and verify residence and patient's ability to return to residence
☐	Verify contact number for patient as well primary support person
VERIFY STABILIZATION OF CLINICAL CONDITION	
☐	Vital signs stable
☐	Temp 96-100
☐	SBP 90-160
☐	HR 60-100
☐	RR 14-22
☐	Pulse Ox >92% on RA for oxygen naïve patients; otherwise O2, 4L/nc
☐	Mental status stable or at baseline >24 hours
☐	Confirm with medical provider and bedside RN that patient is able to manage ADLs independently or with degree of available support at home/facility
☐	Verify lab values stable and any lab follow up: Test_____ Date_____
STATUS OF COVID-19 TESTING	
☐	Date of onset of symptoms_____
☐	Date of initial positive test (if done)_____
☐	If discharging to a non-congregate care setting (home or other), ~~if~~ if no repeat COVID-19 testing, date patient met all of the following criteria_____ ☐ 7 days since symptom onset ☐ 3 days of no fever without antipyretics ☐ 3 days of stable respiratory status
☐	If discharging to a nursing facility or other congregate care setting date patient met all of the following criteria_____ ☐ 14 days since symptom onset ☐ 3 days of no fever without antipyretics ☐ 3 days of stable and improved respiratory status ~~Dates of subsequent negative tests (if done): Date_____ Date_____~~
FOR NON-COVID-19 PATIENTS - INFECTION CONTROL	
☐	Has the patient been in contact with anyone positive for COVID-19?
☐	If yes, date(s) of exposure_____

TOOL 7-A: Health Care Isolation Center Discharge Criteria Checklist to Facility/Home

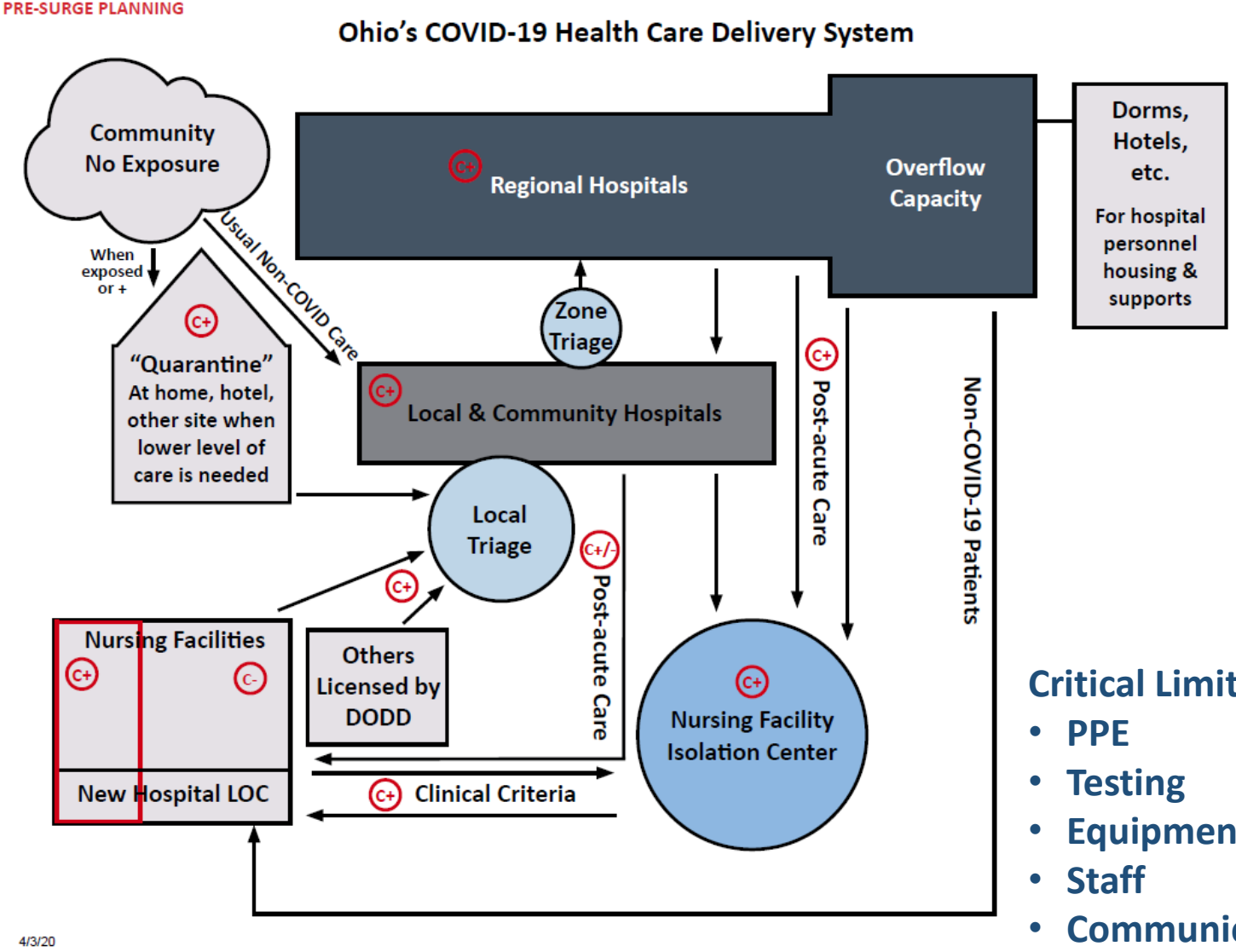
The health care isolation center (HCIC) discharge of an individual with COVID-19 to home or long-term services facility should be made in consultation with the individual's clinical care team, and local or state public health departments, as appropriate.

This checklist is intended to assist with communications when discharging COVID-19 residents from a HCIC. It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. Please check all that apply.

VERIFY RESIDENT CONTACT INFORMATION	
☐	Obtain and verify residence and patient's ability to return to residence
☐	Verify contact number for patient as well primary support person
VERIFY STABILIZATION OF CLINICAL CONDITION	
☐	Vital signs stable
☐	Temp 96-100
☐	SBP 90-160
☐	HR 60-100
☐	RR 14-22
☐	Pulse Ox >92% on RA for oxygen naïve patients; otherwise O2, 4L/nc
☐	Mental status stable or at baseline >24 hours
☐	Confirm with medical provider and bedside RN that patient is able to manage ADLs independently or with degree of available support at home/facility
☐	Verify lab values stable and any lab follow up: Test_____ Date_____
STATUS OF COVID-19 TESTING	
☐	Date of onset of symptoms_____
☐	Date of initial positive test (if done)_____
☐	If discharging to a non-congregate care setting (home or other), if no repeat COVID-19 testing, date patient met all of the following criteria_____ ☐ 7 days since symptom onset ☐ 3 days of no fever without antipyretics ☐ 3 days of stable respiratory status
☐	If discharging to a nursing facility or other congregate care setting date patient met all of the following criteria_____ ☐ 14 days since symptom onset ☐ 3 days of no fever without antipyretics ☐ 3 days of stable and improved respiratory status
FOR NON-COVID-19 PATIENTS - INFECTION CONTROL	
☐	Has the patient been in contact with anyone positive for COVID-19?
☐	If yes, date(s) of exposure_____
☐	Communicate with patient and care partners: COVID status, isolation and PPE requirements

Health Care Isolation Center Plan DRAFT

PRE-SURGE PLANNING



Critical Limiting Factors:

- PPE
- Testing
- Equipment
- Staff
- Communication
- Transportation

Purpose and Role of Health Care Isolation Center (HCIC)

- These centers will play an important role in Ohio's response to COVID-19 by relieving pressure on hospital systems, with coordination within the Public Health Hospital Zone
- A HCIC provides a "COVID level of care" which includes a NF level of care and a COVID diagnosis (+ or presumptive) along with a physicians order
- HCIC serve:
  - » Individuals discharged from a Hospital setting but are not ready to return home
  - » Individuals living in congregate settings who can not be cared for safely where they live

COVID 19 Level of Care

- Level 1: have minor symptoms, recommendation that these individuals remain in their residence
- Level 2: Requires oxygen or other respiratory treatment, they should be monitored carefully for signs of deterioration.
- Level 3: don’t require hospitalization in all cases but may require care beyond a traditional NF, which may include ventilator care.
- Level 4: Require urgent assessment by medical personnel and may require intensive care

Operators of Health Care Isolation Centers

- Providers with a demonstrated history of providing care at acceptable levels of quality and safety
- Facilities not on the Special Focus Facility list (5)
- Facilities with good compliance history
- ODH will consider requests from owners/operators whose buildings meet NF certification requirements
- Operators must have clinical capacity to provide care to individuals with presumed or confirmed COVID-19 diagnoses at Levels 1, 2 and 3 and other comorbidities.
- Interested facilities must follow Appendix 8 for consideration

Reimbursement

- Health care isolation centers will be reimbursed using a tiered flat rate per diem rate system that matches reimbursement to the COVID-19 care needs.
- Draft Rates under consideration:
  - » Level 1: $300 per day
  - » Level 2: $448 per day
  - » Level 3: 820 per day
  - » Level 3 on ventilator: $984 per day
- Franchise Fee
- If individuals receiving care in a HCIC are not eligible for Medicaid, enrollment will be completed by attestation

Technical Assistance & Closure

- The Ohio Department of Health and Ohio Department will provide designated TA teams to support providers.
  - » Start-up
  - » Operation and closure
- Coordination within the Public Health Hospital Zone is required
- The certified beds created for a HCIC shall be temporary. The beds shall not be sold or transferred between nursing facilities.

Ohio Agencies' Consideration of OHCA/LAO 1135 Waiver Requests

PPE Data & Survey

https://www.surveymonkey.com/r/88R2KSD

PPE Estimates and Alternative Surge Location

ID and Introduction

*****PLEASE COMPLETE DAILY BY 5PM TO FACILITATE COORDINATION FOR THE FOLLOWING DAY*****

Please use the back button in the survey to return to a previous question. Do not use the browsers back button or it will reset all responses.

We know everyone is exceptionally busy at this time. We appreciate your effort to keep these data updated so statewide capacity to address the COVID-19 surge can be coordinated. Efficient coordination of resources will help protect all of us and save lives. Thank you for your dedicated service.

The first response to the survey should require less than 10 min to complete. Subsequent updates should require less than 5 min once the data is collected.

Information on how the survey data will be used to allocated PPE, and instructions on how to access PPE through State coordinated resources, are available at the end of the survey.

Facility, Staff and Patient Updates

When answering questions, please include information about what personnel or equipment are at your facility. Even if an item is leased, if it is used/deployed at your facility please include it in your total.

3. Total Available Vacant Beds

12

4. Can You Isolate a Wing/Floor of Your Facility?

- [x] Yes
- [ ] No
- [ ] Not Applicable

Please enter the number of beds that can be isolated below.

6

5. Do You Have Ventilator Capacity (Incl CPAP/BPAP units)?

- [ ] Yes
- [x] No

* 6. Physician Staffing Level

- ○ Adequate
- ✓ Strained
- ○ Critical
- ○ Not Applicable

* 7. Nursing Staffing Level (Including Aides or equivalent)

- ○ Adequate
- ✓ Strained
- ○ Critical
- ○ Not Applicable

* 8. Administrative Staffing Level (All Others)

- ○ Adequate
- ✓ Strained
- ○ Critical

* 9. As Of Today, How Many Residents **Currently** Residing In Your Facility Meet The Following Criteria?

Tested Residents	4
Positive Results	0
Pending Test Results	2

10. Number of Presumed Exposed Patients/Residents Currently In Your Facility **Not Yet Tested**.

4

11. Number of COVID-19 Positive/Suspected On A Ventilator (including C-PAP/B-PAP).

0

12. Total Number Of Patients/Residents Transferred To A Hospital Due To COVID-19 Complications.

0

* 13. Are You Re-Sanitizing Your PPE?

- [x] Yes
- [ ] No

* 14. Gowns (PPE Quality Including Disposable and Washable)

- [ ] 0-1 Days Remaining
- [x] 2-3 Days Remaining
- [ ] 4-7 Days Remaining
- [ ] 8-14 Days Remaining
- [ ] 15+ Days Remaining
- [ ] Not Applicable

Please Enter Total Count Of Gowns In Stock (including those that can be re-sanitized)

43

End Of Survey And Instructions

Thank you for completing the survey!

Your responses will be use to facilitate State work groups to coordinate the ordering of critical supplies and moving people to safe alternative locations during the surge period of the COVID-19 pandemic response.

As your organization needs access to PPE and other information regarding the surge response please contact your county EMA office.

When making a request to the county EMA, be prepared with the following information:

- Details about the incident/situation
- The gap between existing resources and what is needed to handle the incident/situation
- Details about how you have tried to fill that gap locally (asked for volunteers; reached out to the local business community, attempts to purchase goods, etc.)

These details and actions will help facilitate the county EMA to assist you in obtaining critical PPE resources as quickly and efficiently as possible.

FIND YOUR COUNTY EMA HERE:

To learn more about the emergency management system in Ohio, check out the Ohio Elected Officials Guide To Emergency Management: at www.ema.ohio.gov under the heading, “Are You Ready Ohio?”

For additional information, visit coronavirus.ohio.gov.

For answers to your COVID-19 questions, call 1-833-4-ASK-ODH (1-833-427-5634).

ODM Managed Care Provider Agreement Updates

Nursing Facility and Waiver Provider Relief

- In response to the COVID-19 pandemic, ODM with the Managed Care Plans (MCPs) and the MyCare Ohio plans (MCOPs) are implementing significant changes to reduce the administrative burden for NFs and home- and community-based providers.

- Changes and flexibilities are outlined in either:
  - » The emergency provider agreement appendix, or
  - » The clinical or provider guidance jointly issued by ODA and ODM.

- Almost all Medicaid prior authorization requirements have been lifted during the state of emergency.

Provider and Service Specific Requirements

- **PDN –** new PDN requests (including requests for additional hours) shall be approved without prior authorization for 90 calendar days
- **Home Health** – no prior authorization for the first two weeks of service
- **DME –** 90 calendar day supply of DME without prior authorization from participating and non-participating providers except for the items outlined in the provider agreement (e.g. pain pumps, certain mobility devices, etc.)
  - » DME providers shall be paid using the payment rate or methodology described in OAC rule 5160-10-01 (participating and non-participating)

Extension of Current NF Prior Authorizations

- **Nursing Facility Stays –** no prior authorization for new NF stays; level of care must still be determined; concurrent reviews may continue to determine if NF services are still necessary

- **Current NF placements** (i.e. those that occurred before the pandemic):
  - » Plans shall allow all existing prior authorizations to be extended for six months from the renewal or expiration date

Authorization of MyCare Waiver Services

- All services may be authorized or adjusted based on a telephonic assessment of need between the waiver service coordinator and individual

- Services for established individuals may be authorized for the duration of the service plan, as determined necessary by the waiver service coordinator

- 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

Nursing Facility and Waiver Provider Relief

- **Home Delivered Meals**
  - » To ensure individuals have needed meals during the COVID-19 emergency, ODM provided guidance for waiver service coordinators to authorize additional meals
  - » If authorizing additional meals, they should take into consideration the storage capacity of the individual, not the preference of the provider. (Per CMS guidance, CMAs cannot authorize more than two meals per days.)

Nursing Facility and Waiver Provider Relief

- For any service that requires an in-person/environmental assessment, 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 provision (NF respite stay), please consider available alternatives such as staying with an informal support

Nursing Facility and Waiver Provider Relief

- **Telephonic flexibility for waivers:**
  - » Regarding assessments and contact schedules the State is allowing face to face requirements to be replaced with telephonic contact.

- **Waiver disenrollments:**
  - » They will not be proposed unless the individual:
    - – Passes away;
    - – Requests disenrollment;
    - – Moves out of state; or
    - – Transitions between a Fee-for-Service waiver and the MyCare Waiver.

Nursing Facility and Waiver Provider Relief

- **Timely filing:**
  - » MCPs/MCOPs are extending timely filing limits to accept claims from all provider types for up to 365 calendar days from the date of service.

- **Non-participating Providers:**
  - » Non-participating, Medicaid-enrolled providers shall be paid the lesser of:
    - 100% of the Medicaid FFS rate; or
    - The providers submitted charge.

Nursing Facility and Waiver Provider Relief

- **Increasing waiver provider pool:**
  - » The State will permit waiver providers with an active Medicaid provider agreement to provide waiver services across delivery systems without being subject to additional provider standards and certification processes specific to waiver programs.
  - » ODA is working with ODM on process and guidance and will provide additional information when available.
- **Transportation:**
  - » MCPs/MCOPs have implemented transportation protocols due to COVID-19 and are working together to produce a transportation protocol across plans.
  - » More information regarding this will be shared at a later date.

Non-Participating Provider Requirements

- Single case agreements are not required to pay non-participating providers
- Non-participating, Medicaid-enrolled providers shall be paid the lesser of:
  - » 100% of the Medicaid FFS rate; or
  - » The providers submitted charge.
- Plans do not have to pay providers who are excluded from being Medicaid-enrolled providers due to fraud, waste, and abuse

COVID-19 Testing and Treatment

- MyCare Ohio plans (MCOPs) will follow Medicare guidelines regarding testing and treatment of COVID-19
- Medicaid Managed Care Plans (MCPs) shall:
  - » Cover COVID-19 testing and pay at least 100% of the Medicare rate; and
  - » Use the following testing codes (or any newly developed test):
    - U0001 – CDC 2019 Novel Coronavirus Real-Time RT-PCR Diagnostic Panel
    - U0002 – non-CDC laboratory tests for SARS-CoV-2/2019-nCoV
- MCPs and MCOPs shall cover treatment and vaccinations for COVID-19 without restrictions or cost sharing

Telehealth

- Plans must follow Ohio Administrative Code (OAC) rule 5160-1-18 (“Telemedicine”) and 5160-1-21 (“Telehealth During a State of Emergency”)
  - » 5160-1-21 is effective beginning on the date the Governor declared a state of emergency (March 9, 2020)
- Emergency rule revisions and any future telehealth rules or services developed during the time Appendix S is enacted shall be followed

Reporting Requirements

- The following information shall be provided to ODM:
  - » Documentation on the payment of clean claims on a weekly basis
  - » COVID-19 related reports upon request
  - » Implementation status of Appendix S requirements
  - » Any reported drug shortages
  - » Any potential provider shortages (e.g. home health, behavioral health, oxygen, etc.)
- Reports and information shall be submitted using a format and process prescribed by ODM

Additional Requirements

- Plans shall not impose any member cost-sharing for state plan services (including prescriptions drugs) during the time Appendix S is enacted
  - » Patient liability remains a requirement for waiver services and nursing facility care
- Claims shall be accepted from all provider types for up to 365 calendar days from the date of service
- Follow guidance provided in the “Emergency Protocol” for care management (to be updated periodically as needed)
- Provide notification to providers when a member tests positive for COVID-19

ODM LTSS Telehealth Updates

OAC 5160-1-21: Telehealth during a state of emergency

- Applicable for dates of service beginning on March 9, 2020. when Governor DeWine declared a state of emergency.
  - » Claims for dates of service beginning March 9, 2020 and for the duration of the state of emergency will be considered valid
- Applies to Medicaid fee-for-service (FFS), Medicaid Managed Care Plans (MCPs), and MyCare Ohio Plans (MCOPs).
- Billing guidance and details forthcoming (within the next few days)

Telehealth Definition During a State of Emergency

- Delivery of health care services to a patient via synchronous, interactive, real-time electronic communication that includes both audio and video elements; **OR**

- Activities that are asynchronous and activities that do not have both audio and video elements such as: telephone calls, images transmitted through fax, electronic mail

- Medicaid covered individuals can access telehealth services wherever they are located, and providers can also delivering services from nearly any location. Some examples:
  - » Home
  - » School
  - » Temporary housing
  - » Homeless shelter
  - » Nursing Facility
  - » Hospital
  - » Group home
  - » Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)
  - » *The only EXCLUDED place of service: penal facility or public institution, such as a jail or prison*

Telehealth Rendering Providers (MITS Provider Types)

- Physician and Psychiatrist (20)
- Podiatrist (36)
- Psychologist (42)
- Physician Assistant (24)
- Dentist (30)
- Advanced Practice Registered Nurses:
  - » Clinical Nurse Specialist (65)
  - » Certified Nurse Midwife (71)
  - » Certified Nurse Practitioner (72)
- Licensed Independent Social Worker (37)
- Licensed Independent Chemical Dependency Counselor (54)
- Licensed Independent Marriage and Family Therapist (52)
- Licensed Professional Clinical Counselor (47)
- Dietitians (07)
- Audiologist (43)
- Occupational Therapist (41)
- Physical Therapist (39)
- Speech-language pathologist (40)
- Practitioners who are supervised or cannot practice independently:
  - » Supervised practitioners and supervised trainees defined in 5160-8-05
  - » Occupational therapist assistant
  - » Physical therapist assistant
  - » Speech-language pathology aide
  - » Audiology Aide
  - » Individuals holding a conditional license as described in section 4753.071 of the Revised Code
  - » Licensed health professionals providing medically necessary supportive services
- Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting
- Non-Agency Nurses (38)
- Medicaid School Program (MSP) practitioners described in 5160-35 of the Administrative Code
- Other providers as designated by the Director of ODM

Billing Provider Types (MITS Provider Type/Specialty)

- Rendering practitioners listed in the previous slide, with the following exceptions:
  - » Supervised practitioners and supervised trainees defined in 5160-8-05
  - » Occupational therapist assistant
  - » Physical therapist assistant
  - » Speech-language pathology and audiology aides
  - » Individuals holding a conditional license
  - » Registered Nurses (RN) and Licensed Practical Nurses (LPN) working in a hospice or home health setting
- Professional Medical Group (21)
- Professional Dental Group (31)
- Federally Qualified Health Center (12)
- Rural Health Clinic (05)
- Ambulatory Health Care Clinics (50)
- Outpatient Hospitals (01)
- Psychiatric Hospitals providing OPHBH services (02)
- Medicaid School Program Provider (28)
- Other providers as designated by the Director of ODM

Summary of Telehealth for LTSS

Telehealth can be used when clinically appropriate.

- Services that require hands on care, like dressing changes or assistance with bathing, cannot be provided with telehealth.

Nursing Facilities

- Under both ODM's emergency telehealth rule 5160-1-21, as well as ODM's non-emergency telehealth rule 5160-1-18, physicians and other eligible providers may bill for the telehealth services they provide to nursing facility residents.
- NFs are reimbursed for all telehealth related services through the NF per-diem rate.
  - » Nursing Facilities do not bill for the telehealth related services they provide.
  - » Per the telehealth rules, physicians and other eligible providers may bill for the services they provide to nursing facility residents from the practitioner's site in accordance with the rule.
- When nursing facilities provide telehealth related services to their residents, they report the costs they incur for those services on the Medicaid NF cost report using the appropriate cost center codes.
- No changes to MITS, Administrative Code rules, or the Medicaid State Plan are necessary to implement telehealth in NFs.

Summary of Telehealth for LTSS

Hospice services

- ODM is temporarily suspending the face-to-face and in-person requirements found in OAC 5160-56-02 and 5160-56-06. Providers should add the GT modifier to any hospice procedure code on any claims that include at least one telehealth component for that date of service
  - » T2042 routine home care
  - » T2043 continuous home care (this type of care consists predominately of nursing care (it may involve services provided by a home health aide and/or homemaker services)
  - » T2046 select direct care / supervision included in room and board payments in a NF (reimbursed at 95% of the NF's daily rate)
  - » Service Intensity Add-On (SIA) Codes - G0299 for direct care by in-person visit from an RN & G0155 for direct care by in-person visit from a social worker

Home health services, RN assessment service and RN consultation

- Telehealth can be used to satisfy the requirement for a face to face visit with the provider who is ordering home health services. The provider will still need to complete the appropriate documentation and send it to the home health agency.
  - » G0156 Home Health Aide
  - » G0299 Home Health Nursing – RN
  - » G0300 Home Health Nursing – LPN
  - » T1001 RN Assessment
  - » T1001 w/U9 Modifier – RN Consultation
  - » G0151 Physical Therapy
  - » G0152 Occupational Therapy
  - » G0153 Speech-Language Pathology

Summary of Telehealth for LTSS, Cont'd

PreAdmission Screening and Resident Review (PASRR):

- PreAdmission Screenings and Resident Reviews (PASRR) should be completed via the electronic HENS system as they are today as these screenings are primarily via desk review.
- In instances where a face-to-face is required, a telephonic &/or desk review is permissible.
- Level II evaluations can be provided either by telephone or desk review when appropriate.
- There is no system or reimbursement impact as these functions are supported by the level II entities and the applicable contractor.

Brief Billing Guidance

- Medicaid, the MCPs, and the MCOPs are working expeditiously to configure the emergency rule's changes in each of our IT systems in a consistent manner to ease administrative burden on providers. IT system changes spanning Medicaid fee-for-service, MCPs, and MCOPs will be implemented on a unified date (TBD)
- Prior to the implementation date for the IT system changes, providers may either hold claims until the IT system changes are implemented, or providers can submit claims for telehealth services using existing billing guidance.
- If providers choose to submit claims for telehealth service prior to implementation of the IT system changes, it will be very important for providers to continue to use the billing guidance that was in place before the effective date of the emergency rule (i.e. pre-emergency billing guidance.)

Brief Billing Guidance Cont'd

- While providers can deliver all of the services covered under the emergency rule via telehealth beginning March 9, 2020, they should NOT add the telehealth modifier "GT" to claims for services that have been added via the emergency telehealth rule.
  - » Claims may be denied if the GT modifier is added to the new services prior to the implementation date of the IT system changes.
- The emergency rule includes a number of new CPT codes that were not previously covered by the Medicaid program. Providers should hold claims for these new codes until the IT system changes are implemented; failure to hold these claims could result in claims denials.
- Until the IT system changes are made, providers should continue to use pre-emergency place of service codes and requirements for claim submission purposes.
- **Providers must maintain documentation of services delivered via telehealth prior to and after the IT system changes are made.**

Brief Billing Guidance Cont'd

Providers are also encouraged to carefully review Paragraph (E) of ODM's emergency rule, 5160-1-21, regarding submission and payment of telehealth claims. Of particular note:

(1) The practitioner site may submit a professional claim for health care services delivered through the use of telehealth.

(2) An institutional (facility) claim may be submitted by the practitioner site for the health care service through the use of telehealth. Services provided in a hospital setting may be billed in accordance with rule 5160-2-02 of the Administrative Code.

(3) The practitioner site may submit a claim for a telehealth originating fee. If such a practitioner renders a separately identifiable evaluation and management service to the patient on the same date as the health care service delivered through the use of telehealth, the provider may submit a claim for the evaluation and management service and the telehealth originating fee.

ODA/ODM Guidance

ODA and ODM Guidance Documents

- ODA and ODM working collaboratively to issue joint guidance to the field
  - » Care/Case Management Emergency Protocol
  - » Provider Protocol

- Protocols designed to give guidance to case managers and providers who are working with individuals in the MyCare Waiver, Ohio Home Care Waiver, PASSPORT Waiver, Assisted Living Waiver, and Specialized Services Recovery Program

- Guidance is focused on making sure individuals on waivers can remain in the community and receive services safely

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Next Steps

- Meet again tomorrow
- Weekly call (will join the call that occurs weekly with ODH & LTC Provider Associations)