

NASDDDS: COVID-19 Response

Provision of Case Management During Emergencies

Background

Case managers (CM's) play a pivotal role in successful administration of I/DD services. Effective case management supports to individuals with I/DD during a crisis are integral to ensure health, safety, and that a person's needs are met. This requires a reciprocal partnership between the state and the case management entities. The following considerations will assist the case manager (CM) to focus on frequent communication with individuals who are supported to assure current needs are met and health and safety are upheld during periods of emergency.

Steps states can take using the 1115, 1135 and Appendix K options to alleviate federal requirements and make the CM's role more effective:

- Removing requirement for face to face contact and wellness checks;
- Request removal of requirements of signatures on person-centered plans. CM's notes serve as an "attestation" of agreement to the plan;ⁱ
- Ensuring the use of telehealth and other technology to communicate; including the use of previously prohibited technology;ⁱⁱ
- Extend requirements for redeterminations, annual reviews, person-centered planning, and plan updates;
- Waive conflict of interest provisions, if needed, temporarily; and ⁱⁱⁱ
- If CM has a particular role in incident management –provide guidance as to what they must attend to and what can wait.

NOTE: It is good practice to reference the easing of HIPPA requirements so information can be shared with CM's as needed. (Example, additional contact information from day programs).^{iv}

State Actions to Assist Case Managers

- Recognize and re-iterate the essential role of CM's as the 'frontline' of communication with individuals and families;
- Identify where and how CM's can contact state staff for questions, support, and assistance;
- Identify expectations and approaches as to how health and safety requirements can be met;
- Identify examples of what to do for people who are sick- instructions on how to contact doctor, support for accessing testing centers (transportation), support for contacting pharmacies in case a volunteer is needed to drop off medication and support in case of hospitalization;
- Identify how to keep track of people who are temporarily not living in their homes;
- Identify expectations of on call/24 hour availability of CM's- Set priorities and detailed expectations for monitoring and staying in touch with people, especially those living alone/on their own, in personal care homes, or at home with elderly family members;
- Provide clear communication to service coordinators regarding expectations for conducting face-to-face visits via alternative modes, i.e. phone, video conferencing/phoning, etc.;
- Determine and communicate all case management documentation expectations during this time (documenting telephonic, virtual, face-to-face visits/monitoring);

- Communicate to all case management entities expectations for rapid person-centered service plan amendments and approval processes; and
- Allow for conducting rapid service plan amendments and approvals.

State examples in 1915 C Appendix K and 1135 options regarding case management functions:

Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements).

- Reassessments of level of care may be postponed up to one year and services will continue on a case by case basis when conditions do not allow a waiver participant, their representative, or DDA staff to participate in a reassessment due to illness or quarantine to allow sufficient time for the case manager to complete the annual reassessment paperwork.
- Telephonic assessments may occur in place of face-to-face assessments on a case by case basis until impacts of COVID-19 are resolved. Telephonic Initial Assessments will be conducted when needed to prevent exposure related to COVID-19.
- For initial CARE assessments, staff may complete the assessment and person-centered service plan via the telephone or other electronic means and then do a brief in-person visit before moving the assessment to current.
- If the pre-visit questionnaire response indicates it is not safe to do an in-person visit services can be authorized before an in-person visit occurs.
- When level of care is evaluated, it is not required that a physician recommend, certify, or verify that the individual should receive the level of care furnished through the waiver.
- All initial CARE assessments may be sparse, ensuring that mandatory fields are completed with the minimum necessary to complete a minimal care plan.
- Beginning 3/12/2020, initial eligibility assessments of applicants and annual reassessments of active members will be conducted by phone or electronically with the member, their legal guardian (if applicable), and other respondents to avoid exposure of the assessor traveling from home to home. If the assessment is conducted electronically, it must be conducted using a secure network. Any re- assessments that cannot be conducted by these methods will be done as soon as possible and be retroactive to the date of the member's anchor date.
- Active members that choose not to be reassessed by phone/electronically may continue to receive currently authorized services for up to three months after the member's anchor date.

Temporarily modify the person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

- Given the rapid response that will be necessary to ensure participant health and welfare and to avoid delays while waiting for approval and authorization of individual plan changes, documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization. Upon validation that a verbal or email approval was provided for requested changes, authorizations may be backdated for waiver services provided during the period of time specified in Appendix K.
- For service plans that are expiring and currently meeting an affected waiver participant's needs, but a new person-centered service plan is unable to be developed due to ongoing COVID-19 impacts, the

time limit to approve the plan may be extended on a case by case basis when monthly remote or telephonic monitoring is provided to ensure the plan continues to meet the participant's needs.

- Allow remote/telephone individual monitoring by supports coordinators where there are currently face-to-face requirements.
- Individual plan team meetings and plan development may be conducted entirely using telecommunications.
- Person-centered service plans/revisions may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly related to COVID-19 impacts. Telephonic (or other information technology medium) assessments may occur when the assessment cannot occur due to the impacts of COVID-19.
- Verbal approval may be used in place of written signature for PCSP approvals by the person and/or legal guardian when necessary.
- Service plans/revisions may be approved with a retroactive approval date back to 3/12/2020, for service needs identified to mitigate harm or risk directly related to the pandemic. For service plans that are expiring and are currently meeting an affected waiver member's needs, but a new plan is unable to be developed due to ongoing pandemic issues, the time limit to be approved by the anchor date will be extended by 3 months after the anchor date when monthly telephonic monitoring is provided to ensure the plan continues to meet the member's needs. Additional time may be awarded on a case-by-case basis when conditions from the pandemic continue to impede this activity

Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances.

- The requirement to conduct an investigation of any incident of deviation in staffing as outlined in an individual plan may be suspended.
- If this requirement is suspended, providers must report any incidents in which staffing shortages result in a failure to provide care.
- Allow for entry of incidents into the Incident Reporting System outside of typical timeframes in instances in which staff shortages due to COVID-19 occur. Response to incidents will not be impacted.

ⁱ This request may require a 1115 amendment

ⁱⁱ CMS telehealth: <https://www.medicare.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf>.

ⁱⁱⁱ Exemption from COI requirements is allowable in Appendix K. using the only willing and qualified provider option.

^{iv} OCR HIPAA waiver: March 2020, COVID-19 & HIPAA Bulletin: Limited Waiver of HIPAA Sanctions and Penalties During a Nationwide Public Health Emergency