# Case Management Guide

## Ohio Home Care Waiver

**Effective July 1, 2019**

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# A. Waiver Description

The purpose of the Ohio Home Care Waiver is to offer home and community-based services (HCBS) to people with serious disabilities and/or unstable medical conditions who would otherwise be eligible for Medicaid in a hospital or nursing facility. The Ohio Home Care Waiver serves individuals age 0 through 59 with either an intermediate (nursing facility) level of care or a skilled (hospital) level of care.

Individuals enrolled on the Ohio Home Care Waiver must reside in and/or receive HCBS in a private residence or another setting that meets the home and community-based setting requirements set forth in 42 CFR 441.530 and rule 5160-44-01 of the Ohio Administrative Code (OAC).Additionally, they shall participate in a Person-Centered Services Planning process that is consistent with the requirements of 42 CFR 441.301 and OAC rule 5160-44-02 .

The Ohio Department of Medicaid (ODM) -administered Ohio Home Care Waiver is governed by rules primarily set forth in OAC Chapters 5160-44, 5160-45 and 5160-46. These rules provide general guidelines regarding an individual's eligibility for a waiver, provider eligibility, and reimbursement and monitoring.

# B. Waiver Administration and Operation Oversight

Organizationally, the State Medicaid agency (Ohio Department of Medicaid - ODM), is responsible for administration and oversight of the Ohio Home Care Waiver. Within ODM, the Bureau of Clinical Operations, retains authority for the operation of the Ohio Home Care Waiver. The federal government, i.e. the Centers for Medicare and Medicaid Services (CMS), requires waiver programs to ensure the health and welfare of each individual; it is also the fundamental goal of the relationship among ODM, the Case Management Contractors, and the Provider Oversight Contractor. This case management guide details ODM's standards and expectations related to the daily operations necessary to achieve that goal. As program changes occur, and issues and/or potential inefficiencies are identified, ODM may modify the case management guide during the term of the Contract to clarify expectations, improve performance and better meet the needs of individuals served by the Ohio Home Care Waiver. In the event there is a conflict between the terms and conditions of the Contract and this Guide, the Contract is controlling.

ODM contracts with multiple Case Management Agencies (CMAs) to provide assessment and case management services; these contracts were competitively bid. The CMAs operate regionally around the state and are responsible for interfacing with individuals at the local level to ensure access to services. CMA staff perform level of care and comprehensive assessments and reassessments, work with each individual to develop/update Person-Centered Services Plans

(plan of care) tailored to meet individuals' unique service needs, monitor health and welfare, and provide ongoing case management and support. The CMA(s) and their subcontractors shall not provide direct home health or waiver program services to any individuals enrolled on the Ohio Home Care Waiver through the entire term of their CMA contracts. During the first year of an individual's waiver eligibility, the Case Managers who render ongoing case management services cannot be the same Case Managers who determined initial eligibility.

ODM contracts with a single entity to perform provider oversight functions. The Provider Oversight Contractor ensures providers are providing high quality care to individuals enrolled in the Ohio Home Care Waiver; providers are receiving appropriate payment for providing care; providers are meeting eligibility requirements; and providers are following program rules and requirements. The CMAs and the provider oversight contractor must adhere to their agreements with ODM and must comply with ODM administrative rules, regulations and policies. ODM monitors CMA and Provider Oversight Contractor performance and monitors the entire waiver in accordance with a quality management plan based on CMS' waiver assurances. The CMAs and Provider Oversight Contractor must work closely and cooperatively with each other.

ODM continually monitors the quality of its contractors' performance. A variety of monitoring and oversight methods are utilized, and the frequency of the State's monitoring activities varies depending upon the item/activity (i.e., some contract deliverables are monitored monthly while others are monitored quarterly, etc.). Monitoring activities are discussed in the Quality Management Plan.

Refer to the CMS -approved Ohio Home Care waiver application for additional information on the distribution of waiver operational and administrative functions, performance measures, and methods for remediation.

# C. Participant Access, Enrollment and Eligibility

**C-1: Target Groups**

The target groups for the Ohio Home Care waiver are as follows:

*Individuals 0 through 59 years of age who require an intermediate (nursing facility) level of care or a skilled (hospital) level of care.

*Also, within a reserved capacity that has been established for the waiver, the State targets individuals determined by ODM to be eligible for the HOME Choice (Money Follows the Person) Program, and who meet the eligibility criteria for the Ohio Home Care Waiver.

*Individuals enrolled in the Ohio Home Care Waiver who are potentially subject to mandatory enrollment in the MyCare Ohio Waiver shall be eligible for participation in the Ohio Home Care Waiver only until the date on which enrollment in the MyCare Ohio

Waiver commences. Transitions into the MyCare Ohio Waiver shall occur as described in the waiver's Transition Plan.

*ODM is permitted to enroll individuals disenrolling from another NF-LOC waiver, who meet the eligibility criteria for the Ohio Home Care Waiver. These individuals will retain their LOC determination for the period it would have been effective in the waiver from which they disenrolled, absent a change of condition.

**C-2: Maximum Age Limitation**
After individuals turn 60, disenrollment from the Ohio Home Care Waiver must happen before the next annual redetermination is due. Individuals may choose to remain on the Ohio Home Care Waiver, absent a change in condition, until this time. Disenrollment may happen earlier, however, should the individual choose to disenroll prior to that date. The Case Manager's transition planning responsibilities include assisting the individual with enrollment on another appropriate NF-LOC waiver.

**C-3: Individual Funding Level**
The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care, specified for the waiver, up to an amount specified by the State.

At the time of application, if the individual's waiver service needs are determined to exceed $14,700 per month, the applicant will be denied enrollment on the Ohio Home Care Waiver. All applicants denied entrance to the waiver are provided information on fair hearing rights and processes. These individuals may be referred to other state/local home and community-based programs. If no other alternatives are appropriate to meet the individual's needs, he/she will be referred for institutional services.

Individuals enrolled on the Ohio Home Care Waiver are assigned a monthly cost limit, or funding level, based on their service needs as identified in the planning process. The funding level is based on the monthly cost of waiver services as identified in the Person-Centered Services Plan. Funding levels are adjusted when service needs change.

When ODM determines it is appropriate, an individual’s funding level may be increased to accommodate a significant change of condition. The CMA can increase the funding level by up to $1000 a month but only ODM can increase the funding level by more than $1000. When this occurs, the CMA must update the case file in the ODM-approved case management system accordingly.

**C-4: Selection of Entrants to the Waiver**
In general, waiver applicants are considered on a first come-first serve basis according to the signature date on their HCBS waiver referral. However, priority is given to the following persons applying for enrollment on the Ohio Home Care Waiver:

*Children who are from birth up to, but not including, age 21 who:

* Were residing in an inpatient hospital setting at the time of, and at least 14 consecutive days prior to, application for the Ohio Home Care Waiver; or
* Have had three or more inpatient hospital stays during the 12 months prior to application for the Ohio Home Care Waiver.

*Individuals ages 21 through 59 who resided in an inpatient hospital setting for 14 consecutive days prior to application for the Ohio Home Care Waiver.

*Individuals from birth through age 59 living in the community who are at imminent risk of institutionalization due to the documented loss of a primary caregiver.

*Individuals from birth through age 59 who, at the time of application for the Ohio Home Care Waiver, were receiving private duty nursing services for at least 12 consecutive months.

*Individuals from birth through age 59 who are residents of a Medicaid-funded nursing facility at the time of application.

*Within a reserved capacity established by this waiver, individuals from birth through age 59 who are residing in a residential treatment facility, or an inpatient hospital setting, and who have been determined by ODM to be eligible for the HOME Choice (Money Follows the Person) Program.

In order for an individual to be determined to need waiver services, an individual must require:

a) The provision of at least one waiver service, as documented in the Person-Centered Services Plan, and
b) The provision of waiver services at least monthly or, if the need for services is less than monthly, the individual requires regular monthly monitoring which must be documented in the service plan.

Occasionally, the CMA will receive a referral for an individual who has been approved for Medicaid based on their status as an inpatient, or who was deemed eligible as a newborn because they met specific eligibility criteria. ODM offers the following guidance for these cases:

1) Assess the individual's Level of Care (LOC)
   a) If LOC is skilled or intermediate, then assess for home and community-based services needs; and
   b) Determine if there is commercial insurance, what benefits are available, and for what time period.
2) Determine whether the individual's assessed needs can currently be met solely with State Plan Services.
   a) If yes, confirm whether current Medicaid eligibility is "conditional" (e.g. institutional) or "base" Medicaid (low-income, would remain Medicaid-eligible without OHCW/Special Income Level {SIL}),

b) The CMA may reach out to their ODM contract manager to assist in determining the type of Medicaid eligibility active at the time of assessment.

c) If Medicaid eligibility is "conditional," assess for needs *without* State Plan Services as an option.

i) Is there an OHC waiver service identified for at least one assessed need, ***and***
ii) Without the SIL, would the individual be ineligible to receive services through Medicaid State Plan?

- If yes, proceed with OHCW enrollment, assuming all other eligibility requirements are met.
- If no, proceed with denial.

iii) If "base" Medicaid-eligible, assess for needs with State Plan Services as an option.

- Once State Plan services and all other funding sources are exhausted, are there identified needs that waiver services could meet?
  - ❖ If yes, proceed with enrollment, assuming all other eligibility requirements are met.
  - ❖ If no, proceed with denial.

The applicant or authorized representative must agree to participate in the Ohio Home Care Waiver assessment and enrollment processes. This agreement is formally documented with the individual's signature on the Individual on Waiver Agreement and Responsibilities form and shall be obtained upon enrollment, but no later than, the Person-Centered Services Plan development date.

The individual or authorized representative must participate in development of the Person-Centered Services Plan (PCSP) and agree to its implementation by signing and dating the plan. In the event the CMA is unable to obtain a signature at the time the PCSP is developed with the individual and/or their authorized representative, the CMA must document who participated in the development of the PCSP in the case notes, including the date of participation. The signature(s) must be obtained no later than the next face-to-face contact.

**C-5: Evaluation/Reevaluation of Level of Care**

Level of care evaluations and reevaluations are performed by the CMAs, using the ODM-approved assessment tool and are a requirement for determination of initial and ongoing program eligibility. Educational/professional qualifications of CMA staff who perform initial and reevaluation of level of care for waiver applicants include Registered Nurses (RN) and Social Workers (LSW or LISW) licensed in good standing to practice in the State of Ohio.

**C-6: Level of Care Criteria**

As a condition of waiver eligibility, applicants must meet either the intermediate level of care (ILOC) or skilled level of care (SLOC) criteria as set forth in OAC rule 5160-3-08. The age-appropriate, ODM-approved assessment tool shall be used in the evaluation of level of care.

**C-7: Process for Level of Care Evaluation/Reevaluation**

The CMA will be notified when a waiver application has been received by ODM and assigned to the CMA. Upon receipt of the assignment, the CMA must

- create a pending OHCW record on the LTC detail screen in Ohio Benefits, if one was not already created by the Ohio Benefits Long-Term Services and Supports (OBLTSS) agency,
- Add journal notes in the Ohio Benefits system that document receipt of the waiver request and the CMA agency name.

Per its contract with ODM, a CMA is required to complete the ODM-approved assessment tool for priority assessments within **10** calendar days of CMA assignment. Enrollment for individuals who have been assigned as priority referrals, and are found to meet eligibility requirements, must occur no later than **20** calendar days from the date of the CMA assignment (**see below).*

For individuals who qualify as a priority due to being in a hospital or nursing facility at the time of the referral, if there is a delay in their discharge that may affect the CMA's adherence to required timeframes for a priority referral, the CMA must

- pend the case,
- inform their ODM Contract Manager, and
- continue the assessment/enrollment process once the discharge is imminent.

*These cases must not pend longer than 90 days. The CMA must deny the case no later than the 90-day threshold if there has been no discharge.

Assessments assigned as non-priority assessments must be completed within **30** calendar days of the assignment and enrollment for those found to meet eligibility requirements is to occur no later than **45** calendar days from date of the CMA assignment (***see below)*. Criteria for priority assessments is outlined in section C-4 of this guide and within OAC rule 5160-46-02.

During initial evaluation and reevaluation, an RN, LSW or LISW uses the ODM-approved assessment tool to evaluate whether the applicant meets the SLOC or ILOC as described in rule, and the individual is also assessed for Ohio Home Care Waiver eligibility pursuant to OAC rule 5160-46-02. The assessment is documented using the ODM-approved assessment and case management system, and the individual is informed of fair hearing/appeal rights in accordance with OAC 5101:6. Documentation of all level of care evaluations and reevaluations is maintained in the ODM-approved assessment and case management system in accordance with state and federal regulations.

If an applicant is residing in an institution, the assessor must discuss the HOME Choice program with the applicant. If the applicant is interested in HOME Choice, the CMA must complete a HOME Choice Application on-line, which can be accessed at http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx .

Once a program eligibility determination has been made, the CMA must update the OHCW record on the LTC detail screen in Ohio Benefits with an approval or denial status. When the

CMA has not made a program eligibility determination within 45 days following the receipt of the waiver referral, the CMA must provide a status update to the county department of job and family services (CDJFS) via a journal note in Ohio Benefits. Failure to provide the status update to the CDJFS may result in a denial of benefits.

(**) Documentation of follow up by the CMA on cases left pending beyond the 20 (priority) and 45 (non-priority) day thresholds must occur *no less than on a weekly basis in both Ohio Benefits and the clinical case record*. **ALL** cases (priority and non-priority) must be either approved or denied in Ohio Benefits no later than 90 calendar days from the date of the assignment to the CMA.

| | Priority | Non-Priority |
|---|---|---|
| **Face-to-Face Assessment** | No later than 10 calendar days from date of assignment | No later than 30 calendar days from date of assignment |
| **Program Eligibility Determination** | No later than 20 calendar days from the date of the assignment<br><br>**See exception below* | No later than 45 days from the date of assignment<br><br>***See exception below* |
| **Program Eligibility Documentation in Ohio Benefits (Priority *and* Non-Priority Cases)** | */** If a case must be left in the pending status for longer than 45 days from date of assignment, *there must be documentation in Ohio Benefits* (and within the individual's case record) from the CMA indicating the reason the record remains in a pending status.<br><br>*ODM requires an eligibility decision (or denial) to be entered into Ohio Benefits no later than 90 days from date of assignment.* | |

The CMA must not approve an individual for the OHCW in the ODM-approved case management system until they verify there is an approved LTC program block for OHCW in Ohio Benefits and an open waiver benefit plan in MITS.

For annual reevaluations, the CMA must contact all team members the individual would like included, to invite them to participate in the annual assessment. Annual face-to-face assessments are conducted and program eligibility determination must be made no more than 365 calendar days after the previous eligibility determination.

The CMA must maintain documentation of each assessment and evidence gathered to make all determinations. It is the Case Manager's obligation to check Medicaid eligibility on the initial enrollment and every 90 days to ensure that the individual remains eligible for Medicaid.

**C-8: Denials/Disenrollments**

At any time during the eligibility determination process, the CMA may deny the waiver application if the CMA has not made contact with the applicant after at least three attempts at

varying times, and on at least three different days. The CMA must maintain documentation in the clinical record of all attempts to reach the applicant.

If it is determined during the assessment, or at any point during enrollment on the waiver, the individual does not meet program eligibility criteria for the Ohio Home Care Waiver, the CMA must recommend the individual for denial or disenrollment and inform the individual of fair hearing rights. The CMA shall, with the individual's permission, refer the individual to other appropriate resources, including but not limited to an Ohio Department of Developmental Disabilities (DODD) or an Ohio Department of Aging (ODA) -administered waiver program. The CMA must provide the individual with the contact information for the appropriate local agency or community resource.

The CMA may submit a recommendation for waiver disenrollment to ODM if, at any time, the CMA cannot ensure health and welfare of the individual or is unable to develop or implement a Person-Centered Services Plan that can ensure the individual's health and welfare. Further detail on this process can be found in section H-2(b) of this guide.

**C-9: Assessment**

The assessment process is designed to identify an individual's needs, strengths and formal/informal supports, as well as to establish the individual's level of care. It assesses the individual's ability to live independently, as well as their ability to direct their own care. Assessments are completed for waiver applicants and waiver-enrolled individuals at least once per year, in addition to ongoing, as-needed assessments performed as a part of the CMA's day-to-day operations.

- The CMA will complete assessments using the ODM-approved assessment tool, information gathered from the waiver individual and, to the extent possible, from the individual's informal caregivers and/or authorized representative. Assessments will also include information from the individual's current professional support team (e.g. physician, specialists, providers, etc.) and any other sources identified by the individual as having information that will be useful in determining their level of care and need for services.
- The assessment process must include an evaluation of the individual's current or intended community residence.
- At the individual's request, the assessment may be terminated at any time and can be rescheduled at a later date and time, within prescribed timelines.
- The assessment will include a review of the individual's care needs, goals, strengths, and preferences.
- The assessment process includes a summary of needs, progress and response to care or treatment, as well as outcomes.
- If at any time during the assessment process the individual fails to meet any of the eligibility or enrollment criteria the Ohio Home Care Waiver program, the CMA will determine the individual should be denied or disenrolled from the program and will inform the individual of fair hearing rights.

**C-10: Ongoing Assessment**

The CMA must assess the individual's care needs on an ongoing basis and address needs as they arise. The CMA is not required to complete the entire ODM-approved assessment tool when engaging in ongoing assessment activities. The Case Manager will consider information gained through communication with the individual, authorized representative, providers, and other members of the individual's team in order to promptly and appropriately address the individual's personal circumstances.

**C-11: Event Based Assessments**

ODM requires the CMA follow up on any reported, actual or potential significant change(s). A significant change may include, but is not limited to:

- Loss of primary caregiver/informal support
- A physical or behavioral health facility admission
- Change or deterioration in the individual's condition, including election of hospice benefits
- Change of residence
- Three reported incidents in 90 days
- Failure to use waiver services for 30 days

The CMA must make contact with the individual by the end of the next full calendar day following the CMA's knowledge of an actual or potential significant change. If it is determined that a significant change occurred, and the individual is in the community at the time of the determination, the CMA must complete a visit and an event-based update, using the ODM-approved assessment tool, by the end of the third full calendar day following the CMA's determination.

For individuals who are in a facility at the time it is determined a significant change occurred, contact with the discharge planner to coordinate post-discharge care is expected. If the discharge planner is unable to be reached, the CMA must document their attempts to connect with them, including documentation substantiating the Case Manager's contact information was provided to the facility for follow up with the CMA. For individuals discharging from facilities, the face-to-face event-based update by the Case Manager must occur within three calendar days of learning the individual has been discharged from the facility.

A face-to-face visit and event-based update assessment by the Case Manager, within three calendar days is required following identification of a significant change due to reasons other than an inpatient stay. The completion of a full, comprehensive, event-based assessment will change the annual reassessment date. Partial updates to the ODM-approved assessment tool (assessment amendments) will not have an impact on the annual reassessment date.

**C-12: Freedom of Choice**

At the time of initial assessment and reassessment, the CMA Case Managers are responsible for providing written materials and explaining information to individuals about feasible alternatives,

and for informing individuals about their freedom of choice between waiver and institutional services.

Individuals will receive an ODM-approved handbook from the CMA at the time of enrollment and at the time of annual reassessment. The handbook details feasible alternatives that are available, including free choice of providers and the option to receive waiver services or institutional care. It also informs individuals of their rights and responsibilities while enrolled on the waiver. The CMA will furnish an ODM-approved agreement for individuals to sign documenting their choice of waiver services in lieu of institutional services.

Individuals will have the ability to change their Case Manager within the CMA quarterly, if desired. Individuals also have the right to choose and change their CMA annually, or on a case-by-case basis as determined by ODM. Individuals will be notified by ODM of the open enrollment date by letter. During open enrollment, individuals will be allowed to change CMA with no justification needed. If in the interim, an individual would like to change CMAs, they must submit justification with their request to the contract manager through the bureau's mailbox at BCO@medicaid.ohio.gov.

Individuals enrolled on the Ohio Home Care Waiver have the right to select an eligible provider of their choice for any Medicaid and/or waiver service, within the authorized service. Case Managers must ensure the utilization of third-party benefits and Medicaid State-Plan services prior to the authorization of waiver services and are responsible for ensuring that authorized service providers are viable to render the service. The CMA is responsible for ensuring that individuals are afforded their right to select the provider of their choice and assist, to the extent desired, in the selection process. The CMA must provide ongoing support to individuals throughout the provider selection process to facilitate timely coordination and start of service. Support includes, but is not limited to, using the approved case management system to post referrals for services, as well as conducting direct outreach to enrolled providers (phone calls and emails) until all service needs have been fully staffed.

Individuals can select any combination of agency and/or non-agency providers. The CMA is responsible for ensuring that the individual has selected an adequate number of providers to ensure full coverage of services authorized in the Person-Centered Services Plan. This includes, but is not limited to, assisting individuals with identifying potential providers, contacting the providers to determine interest, and linking individuals to interested providers. If an individual fails to meet the requirements set forth in OAC 5160-45-03 (e.g. inability of the individual to meet participant responsibilities, or if health and welfare is unable to be assured), the individual may be required to receive services from only agency providers and hearing rights shall be issued in accordance with division 5101:6 of the Administrative Code.

# D. Case Management

Case management, as described in the Contract and this Case Management Guide, provides holistic care management to the individual. The CMA shall ensure person-centered care by including the individual in all decisions about his/her care. The Case Manager is the lead coordinator for the team process and person-centered services plan development and provides appropriate linkage and referral to community resources and services.

**D-1: Activities**

Case management activities include, but are not limited to:

Eligibility determination and enrollment

- Level of care determination
- Assessment to determine needs
- Linkage and referral to community resources

Ensuring Health and Welfare

- Immediate action, reporting incidents and prevention from harm planning
- Monitoring the individual's services and service quality, including providing oversight that waiver services are being delivered according to the type, amount, frequency, duration and scope reflected on the Person-Centered Services Plan
- Monitoring the individual's environment and ensuring action when needed
- Linkage and referral to community services, providers, and resources to meet the needs of the individual

Care Coordination

- Developing and maintaining the Person-Centered Services Plan in conjunction with the individual
- Facilitating a team and person-centered planning process
- Coordinating services across all team members, including providers
- Partnering with Medicaid Managed Care Plans (MCPs) to facilitate collaboration, coordination and communication for MCP adult extension members who are receiving Ohio Home Care Waiver services

Customer Service

- Listening to the individual and addressing problems related to health, safety and welfare and services in a professional manner
- Providing useful and meaningful support to the individual and his or her team

- Responding to calls and other communications timely (no longer than 2 business days)
- Anticipating the needs and accommodating the desires of the individual and his or her team in order to most effectively meet the individual's needs
- Offering assistance and following through within the agreed upon timeframe
- Communicating with courtesy and purpose

**D-2: Case Management Practice Standards**

1. The staffing level for case management must be maintained in accordance with the contract. Additional detail on staffing levels can be found in section H of this guide.

2. The Case Manager must be a licensed social worker, licensed independent social worker, or registered nurse with current Ohio licensure in good standing.

3. The Case Manager must maintain the minimum contact and visit schedules with the individual in accordance with the specifications outlined in the approved waiver application and section F-10 of this guide.

4. The Case Manager must maintain confidentiality of the individual's data in accordance with the Health Insurance Portability and Accountability Act regulations (HIPAA).

5. The Case Manager must report and document incidents in accordance with OAC rule 5160-45-05 and the requirements of this guide.

6. The Case Manager must revise and update the individual's Person-Centered Services Plan as the individual's needs and resources change. The Case Manager must complete updates within 10 calendar days of an identified need or request that was not yet authorized, or within 48 hours if a verbal authorization was provided at the time of the request.

7. The Case Manager must inform individuals of their rights and responsibilities while enrolled on the waiver program.

**D-3: Case Management Process Requirements**

1. The Case Manager must explain the role and responsibilities of case management to the individual and, if applicable, his/her authorized representative both verbally and in writing. This must include an explanation of the CMA's role related to ODM in the operations of the waiver program, as well as in relation to the Managed Care Plan (when applicable).

2. The Case Manager must provide current contact information to the individual. The Case Manager must also ensure that the individual has the CMA's contact information accessible to family members and emergency personnel. The CMA shall furnish contact numbers for the Long-Term Care Ombudsman Office and Medicaid Hotline. Individuals shall be educated on their right to contact any of these entities for assistance or to notify them of concerns.

3. The Case Manager must provide each individual a copy of the ODM-approved Waiver Handbook at enrollment and at least annually.

4. The Case Manager must obtain permission from the individual prior to contact with any members of the individual's team to request information about care and treatment plans in effect, and to request notification of any changes in plans of care and treatment to reduce duplication of services. At the time permission is obtained, the individual must be informed of the right to revoke permission to any person at any time within the rules and requirements of the waiver program. Permission must be renewed annually. The Case Manager must provide his or her contact information to all members of the individual's team.

5. The Case Manager must assist the individual with obtaining providers to meet assessed needs. While waiver service requests may be posted for providers on the case management agency's secure portal, the case manager must employ additional approaches to meet individuals' service needs when the portal method is not successful. In situations when the case manager furnishes a list of provider options to the individual for consideration (including waiver and non-waiver funded services), the case manager is responsible for timely follow up with the individual to ensure the gap in care has been resolved. This includes providing assistance (e.g. reaching out to providers directly on behalf of the individual) when the individual demonstrates a need and desire for linkage but has not or is unable to follow up with a provider on their own behalf.

6. For all service additions and permanent changes to schedule, service and/or provider, the Case Manager must contact the individual within one business day after the service addition or change was to be initiated to confirm that it is in place and that the individual is satisfied with the service addition or change. This contact will be documented in the clinical record.

7. The CMA must obtain the signature of the waiver service provider to serve as acknowledgement of receipt and agreement to furnish the authorized service as documented on the Person-Centered Services Plan.

8. The Case Manager must contact service providers to verify delivery of waiver services in the type, amount, frequency, scope, and duration as identified on the individual's Person-Centered Services Plan no later than three business days after the scheduled service start date. This contact will be documented in the clinical record.

9. The Case Manager must maintain ongoing communication with the individual and members of the team, including all service providers listed on the Person-Centered Services Plan. This will allow for the identification of, and the opportunity to remediate any problems with service delivery. This will also assist in the identification and follow up of potential risks to the individual's health and welfare.

10. The Case Manager must monitor the quality of service delivery and care provided by all authorized Medicaid providers. This includes the review of physician orders compared to service delivery records, medication review, incident reports, and other documentation of service delivery.

11. The CMA supervisor must assign each individual an acuity level. The Case Manager will conduct a visit within the prescribed guidelines and/or when there is a need or a request for visit. The Case Manager must monitor for changes in the individual's circumstances, and update the level of case management contact/schedule as indicated. More frequent monitoring and contacts may occur depending on the individual's unique situation and upon consultation with the care team.

    - Case Manager "contact" is defined as a face-to-face visit, phone conversation, email exchange or other electronic communication with the individual that ensures the transfer of information between the Case Manager and the individual. Electronic communications without response are not considered a Case Manager contact.

12. A visit may also be designated as a contact within the prescribed schedule, if the Case Manager completes a face-to-face visit when it is time for a contact. The Case Manager must document in the communication notes the reason the face-to-face visit would be considered a contact. A visit cannot serve as both an in-person visit and a contact.

**Contact schedules and acuity levels are described in more detail in sections F-10 and F-11of this guide.**

**D-4: Coordination with Managed Care Plans**

Some individuals who are enrolled on the Ohio Home Care Waiver are also receiving their traditional Medicaid state plan services through managed care plans (MCPs). These individuals are known in Ohio as 'Group 8' (i.e. Adult Expansion) because they are eligible for Medicaid through Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Communication and collaboration between the CMA and the Managed Care Plan is critical for these individuals who are jointly served. At a minimum, the CMA must:

- Identify the Ohio Home Care Waiver case manager and provide contact information to the MCP;
- Transmit requested data, information and reports in a timely manner – including but not limited to assessments and service plans;
- Communicate with the MCPs regarding issues such as: change in Ohio Home Care Waiver case manager, significant change events, assistance when a need for a state plan service is identified, provision of services, and a change in behavior and health status;
- Work with the MCP to delineate roles and responsibilities between the contractor and the MCP in order to avoid duplication or gaps in services; and
- Ensure messaging on the roles and responsibilities of both entities is clear in the messaging to jointly served individuals.

**D-5: Waiver Service Provider Signature Requirement**

The Ohio Home Care Waiver service provider's signature must be obtained during new waiver service initiation, assignment of a new waiver provider and following substantial changes in waiver service delivery. A substantial change in waiver service delivery is defined as a change that permanently alters an individual's typical/routine schedule. An ongoing change in amount, duration, frequency and/or scope is considered substantial. Only the waiver service provider affected by the change needs to provide a signature. If the CMA is uncertain if a change is substantial, the waiver service provider's signature should be obtained.

The CMA must provide the person-centered services plan to the waiver service provider and make attempts to obtain the signature prior to service initiation. If the CMA is unsuccessful in obtaining the signature prior to service initiation, waiver services may be provided as authorized per the person-centered services plan while the CMA continues efforts to obtain the signature. The CMA is responsible for making, at minimum, three attempts to obtain a signature. If the CMA is unable to obtain the signature prior to service initiation, a second attempt must occur no later than 30 calendar days after service initiation. If the waiver service provider does not sign and return the signature sheet, a third attempt needs to occur no later than 60 calendar days after service initiation. The CMA is responsible for maintaining the dates of all waiver provider signature requests in the case management clinical record.

- Signature sheets may be provider-specific instead of requiring one document inclusive of signatures from each provider.
- When the waiver service provider signs the plan, he/she agrees only to the portion of the plan that is relevant to the service(s) he/she provides.
- The waiver service provider may provide the signed person-centered services plan in person, via mail, fax, or email.
- Language may be added to the person-centered services plan, included on a provider signature page, or added to a provider portal if the CMA's case management system functionality allows for a "check box" indicating acknowledgement.

# E. Participant Services

**E-1: Ohio Home Care Waiver-Funded Services**

In all circumstances, community resources, third party insurance, and Medicaid State Plan must be used before authorizing waiver-funded services.

Individuals enrolled in the Ohio Home Care waiver may receive the following waiver services:

- Adult Day Health Center Services
- Community Integration
- Community Transition

- Home Care Attendant
- Home Delivered Meals
- Home Maintenance and Chore
- Home Modification Services
- Out-of-Home Respite Services
- Personal Care Aide
- Personal Emergency Response System
- Supplemental Adaptive and Assistive Devices
- Supplemental Transportation
- Waiver Nursing

Definitions for waiver services, along with provider requirements and specifications, can be found in OAC Chapter 5160-44 and OAC rule 5160-46-04.

**Adult Day Health Center Services:** Adult Day Health Services feature structured activity planning, health assessment, supervision and hands on assistance with activities of daily living, among other offerings, and are available for both half- and full-day services. Other support services (i.e., nursing, Personal Care Aide) may not be used while the individual attends Adult Day Services. Round trip transportation to and from the Adult Day Health site is included as part of this service. Additional information about Adult Day Health Services can be found in OAC rule 5160-46-04.

**Community Integration Services:** Community integration services are independent living assistance and community support coaching activities that are necessary to enable an individual to live independently and have access to, choice of, and an opportunity to participate in a full range of community activities. Independent living assistance helps individuals to manage their households and personal affairs, self-administering medications, and retain their community living arrangements. Independent living assistance can be furnished through telephone support, in-person support or travel attendant activities, as applicable to the tasks performed. Community support coaching includes providing information and training to an individual, so the individual can achieve the community integration goals identified in their person-centered services plan. Refer to OAC rule 5160-44-14 for more information.

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**Community Transition Services:** Community transition services pay for non-recurring living expenses for individuals transitioning from an institutional setting to a home and community-based setting that is compliant with OAC rule 5160-44-01. Community transition services include expenses necessary to enable an individual to establish a basic household. Services are payable to the extent they are determined reasonable and necessary through the person-centered service planning process and are clearly defined in the individual's Person-Centered Services Plan; and they are authorized by the CMA. Such authorization shall only occur if no other person, including the landlord, has a legal or contractual responsibility to fund the expense, and if family, neighbors, friends or community resources are unavailable to fund the expense.

Community transition services may be authorized up to 180 consecutive days prior to an individual's transition from an institutional setting into the community. It shall be provided no later than 30 days after the date on which the individual enrolls on the waiver. The service is limited to $2,000 per waiver enrollment. More information on community transition services is available in OAC rule 5160-44-26.

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**Home Care Attendant:** Home Care Attendant services are waiver services available to individuals who meet the specific requirements of Ohio Administrative Code Rule 5160-44-27 and are able to be provided by an unlicensed non-agency provider in accordance with the aforementioned rule. Home care attendant services include, but are not limited to, tasks that would otherwise be performed by an RN or LPN at the direction of an RN. There is no comparable service available on the state plan. Home Care Attendant services must be delivered at the direction of the individual or authorized representative on a waiver program; therefore, this service cannot be used as respite. Additional information about Home Care Attendant services can be found in OAC rule 5160-44-27.

**Home-Delivered Meals:** Dietary-appropriate home-delivered meals may be used when an individual needs assistance with meal preparation but can eat independently. Home-delivered meals may be used at the same time as, or when a Home Care Attendant, Personal Care Aide, or Nurse is in the home. If authorizing home delivered meals concurrently with these services, the authorization for the aforementioned services should be adjusted so as not to account for meal preparation. Up to two meals may be authorized per day based on the assessed need of the individual; however, meals shall not be provided in order to supplant or replace the purchase of food or groceries. Planned multiple meal delivery shall not exceed 14 meals that are compliant with food storage and safety requirements. For more information on Home Delivered Meals, refer to OAC rule 5160-44-11.

**Home Maintenance and Chore Services:** Home maintenance and chore is a service that maintains a clean and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability. Services shall not exceed a total of $10,000 in a calendar year per individual. They may be authorized up to 180 consecutive days prior to an individual's transition from an institutional setting into the community. Covered home maintenance and chore services include: minor home maintenance and repair, heavy household cleaning, non-routine disposal of garbage and yard maintenance posing a threat to the individual's health, safety, and welfare, and pest control and related tasks to prevent, suppress, eradicate, or remove pests posing a threat to the individual's health, safety, and welfare. More information about home maintenance and chore services, including the authorization process, is found in Appendix C and OAC rule 5160-44-12.

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**Home Modification Services:** Home modifications are environmental adaptations to the private residence(s) of the individual required by the individual's person-centered services plan, that are necessary to ensure the health, welfare and safety of the individual or that enable the individual to function with greater independence in the home. Such adaptations include, but are not limited to, the installation of ramps and grab bars, widening of doorways, modification of bathroom or

kitchen facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Home modifications may be authorized up to 180 consecutive days prior to an individual's transition from an institutional setting into the community. Home Modification Services are limited to up to $10,000 per calendar year, based on the date the service is completed. Additional detail on the process for authorizing home modifications can be found in OAC rule 5160-44-13 and Appendix B of this guide.

**Out-of-Home Respite Services:** Out-of-home respite services are services delivered to an individual in an out-of-home setting to allow respite for caregivers normally providing care, must include an overnight stay, and can be provided only in an Intermediate Care Facility for Individuals with Intellectual Disabilities, nursing facility or other licensed facility approved by Ohio Department of Medicaid. The Out-of-Home Respite provider must make, at a minimum, waiver nursing services (as set forth in OAC 5160-44-22), personal care services (as set forth in OAC 5160-46-04), and three meals per day that meet the individual's dietary requirements available to the individual during their stay. For more information on Out-of-Home Respite Services, refer to OAC 5160-44-17.

**Personal Care Aide:** Personal care services are available to individuals as both an intermittent and continuous service within the service requirements. These services assist the individual with activities of daily living and instrumental activities of daily living needs. The "Norms" assessment tool may be used to guide the amount and scope of services that are needed. Additional information on Personal Care Services can be found in OAC rule 5160-46-04.

**Personal Emergency Response System**: A Personal Emergency Response System (PERS) is available to individuals who can be left unattended for periods of time and are able to use the device to summon emergency assistance, if needed. Personal emergency response system is a service with a monitoring, reminder and/or reporting component available to support individuals' independence in the community. PERS include telecommunications equipment, a central monitoring station (station), and a medium for two-way, hands-free communication between the individual and the station. Personnel at the station respond to an individual's alarm signal via the individual's PERS equipment. For more information, refer to OAC rule 5160-44-16.

**Supplemental Adaptive and Assistive Devices (including Vehicle Modifications):** This waiver service includes medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. All supplemental adaptive and assistive device services shall be prior-approved by ODM or its designee. ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

Supplemental Adaptive and Assistive Devices are limited to up to $10,000 per calendar year, based on the date the service is completed or delivered.

ODM will not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year unless there is a documented need for ongoing medical supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

ODM shall not approve the same type of vehicle modification for the same individual within a three-year period unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

Additional information on supplemental adaptive and assistive devices, including vehicle modifications can be found in OAC rule 5160-46-04 and Appendix A of this guide.

**Supplemental Transportation Services:** Supplemental transportation services are transportation services that are not available through any other resource, that enable an individual to access waiver services and other community resources specified on the individual's Person-Centered Services Plan. Supplemental transportation services include but are not limited to assistance transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.

Supplemental transportation services are available to help individuals access the community, but they cannot be used for transportation to medical appointments. The individual must use community resources such as non-emergency transportation, ambulette, or ambulance services as arranged by the local county department of job and family services for medical appointments. Refer to OAC rule 5160-46-04 for additional information.

**Waiver Nursing:** Waiver nursing services are nursing tasks and activities provided to individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. Waiver nursing services are available to individuals who have intermittent or continuous skilled nursing needs. Nursing tasks must be performed within the nurse’s scope of practice and may include personal care and incidental home-making services as long as it is relevant to the care of the individual and does not substantially lengthen the nurse’s visit. The Private Duty Nursing acuity tool may be used to guide the amount and scope of services that are needed. Waiver nursing shall not be used in lieu of similar services available through third-party insurers, community supports, resources or other Ohio Medicaid state plan services when it has been determined an individual’s needs can be met by those services. For more information about waiver nursing services, please refer to OAC rule 5160-44-22.

The Person-Centered Services Plan must address the need for continuous nursing care utilizing State Plan Private Duty nursing to the extent available.

An assessment of the individual’s needs shall be performed by the CMA prior to the individual receiving waiver services for the first time, prior to any change being made to an individual's services, and any time the Case Manager is informed that the individual receiving services has experienced a significant change, including an improvement or a decline in condition.

When developing the Person-Centered Services Plan, the Case Manager must first explore the availability of community resources, followed by State Plan options prior to initiating waiver services. The Person-Centered Services Plan must address the need for intermittent nursing care utilizing State Plan Home Health Nursing to the extent available. State Plan Home Health nursing cannot be used as respite; however, Waiver Nursing can be authorized to meet a respite need. Aide visits that are more than four hours in length must be authorized utilizing waiver personal care.

**E-2: Services Available 180-Days Pre-Enrollment**
**180 Day Pre-Enrollment Process**

Services that may be authorized and provided up to 180-days prior to enrollment in the Ohio Home Care Waiver:

- Home Modification
- Community Transition
- Home Maintenance and Chore

Pre-enrollment service coordination activities include posting for bids on an applicable service, referring for a service that does not require a bid, reviewing bids, authorizing the service on the PCSP, communicating with the individual, their authorized representative, or the service provider as necessary to secure the service and ensure its completion, and verifying the pre-enrollment service was delivered as authorized on the PCSP.

**E-3: Waiver Service Budget Limits and Prior Authorization**

Individual funding limits are determined at the time of entry onto the waiver, with modifications occurring subsequent to changes in the individual's condition or circumstances. Individuals are assigned a monthly cost limit by the CMAs based on their service needs as identified in the assessment and Person-Centered Services Planning processes. The cost limit, or cap, is based on the monthly cost of waiver services as identified in the Person-Centered Services Plan. The Person-Centered Services Plan reflects all authorized services, including the cost of waiver services. The cost limit excludes home modification services and supplemental adaptive and assistive device services.

Cost limits are adjusted when service needs change. Some changes can be made at the CMA level and are subject to CMA supervisory approval. However, when adjustments result in significant increases or services exceeding $14,000 per month, the CMAs must obtain prior authorization from ODM. Prior authorization is used whenever an individual requests, or a Case Manager determines the need for an increase in services that causes the service authorization to go over the baseline. The baseline is an average planned monthly cost of state plan and waiver services.

Conditions under which prior authorization is required include, but are not limited to:

• An increase in monthly service authorization amounting to $1000 over the current baseline.

• An increase in service authorization amounting to $1000 over the previously authorized amount of Private Duty Nursing (PDN) or, if applicable, a combination of PDN and Home Health services for individuals who are newly enrolled on the Ohio Home Care Waiver.

• Any service authorization of $14,000 or more in a month (excluding Home Modifications, Adaptive/Assistive Devices, and Home Maintenance and Chore Services).

• Person-Centered Services Plans that include more than 112 paid hours per week of personal care aide services, nursing, home care attendant services, adult day health, or any combination of these or other like services, regardless of funding source, authorized for more than four weeks.

Individuals receive a revised copy of the Person-Centered Services Plan any time changes are made and may access their current Person-Centered Services Plan at any time via the ODM-approved waiver web portal. Individuals are notified by the CMAs in writing of their hearing rights related to service changes which affect their cost limits. Hearing rights are also generated subsequent to denial of an individual's request for a change or increase in funding level.

*Prior authorizations are not required for the use of post-hospital benefits as described in section E-5 of this guide.

Prior Authorization Review Expectations

Prior authorization requests will evaluate the following domains:

- Health and Welfare
- Cognitive
- Physical
- Environmental

The CMA must submit the request for prior authorization within five business days of the individual's request or the determination of need. ODM will review requests and respond to the CMA within 10 business days of submission. The CMA has up to five business days to respond to a request from ODM for more information or withdraw the request.

ODM will review prior authorizations in order of receipt unless the CMA requests a priority review.

Priority Reviews

ODM will expedite the review of a prior authorization as a priority only in these circumstances:

- The requested services meet the criteria for an emergency over $12,000 as described below, or
- The need for the increased services that meet the other criteria for a prior authorization when there are extenuating circumstances relating to a significant change of condition. An event-based assessment must accompany the prior authorization request.

The CMA will submit all requests for priority review by e-mail to PDN_BCSP@medicaid.ohio.gov. ODM will determine if the request meets criteria for a priority review.

Emergency Authorization

As an additional safeguard to ensure individuals have access to needed services in the event of an emergency, the previous description of prior authorization will not delay an individual's access to urgently needed services. The CMAs have the ability to approve temporary increases in services up to $12,000 for no more than 21 calendar days. Emergency increases over $12,000 must be prior-authorized by ODM.

ODM will not repeat, extend or renew an emergency authorization. If the individual is expected to need the increase in services beyond 21 days, the CMA must submit a prior authorization request to ODM for consideration.

ODM must prior authorize any emergency request over $12,000.

**E-4: State Plan Nursing Services**

All services must be used and approved as directed in the OAC rule 5160-12-01 and/or 5160-12-02.

Nursing Consultation - An RN consultation service shall be performed as required by rule 5160-12-08 of the Administrative Code for State Plan Home Health nursing services, rule 5160-12-02 of the Administrative Code for Private Duty Nursing services, and rule 5160-44-22 of the Administrative Code for waiver nursing services.

**E-5: Healthchek**

OAC rule 5160-12-01 requires that when increased Home Health services under the Healthchek program are requested, individuals under age 21 are to be evaluated to determine if they meet a comparable institutional level of care. The evaluation does not authorize services, nor is it a level of care determination for any purpose other than comparability for purposes of establishing the need to exceed the established State Plan Home Health limitations.

The comparable level of care must be established when the increased home health services are requested and must be reestablished at least annually. Families or providers must request the comparable level of care evaluation through ODM. ODM assigns evaluations randomly to CMAs, who complete a face-to-face evaluation and inform the provider of the outcome. If

the CMA is unable to contact the family to schedule a face-to-face evaluation, it shall contact the provider to determine if the evaluation is still needed. When the outcome demonstrates that the individual meets a comparable institutional level of care, the CMA must send a notice to the requesting provider agency that includes the time span for which the individual would be eligible for the increased service.

When the outcome demonstrates the child does not meet a comparable institutional level of care, the evaluation and the justification for the denial must be sent to ODM for review and final determination before the CMA issues a decision. All the information must be sent to the following mailbox: MCD PDN_BCSP@medicaid.ohio.gov . If ODM agrees with the CMA that the individual does not meet a comparable institutional level of care, ODM will issue hearing rights to the individual and defend any adverse action in a hearing. The CMA must also notify the provider of the denial of Healthchek.

ODM does not have specific forms the CMA must use for Healthchek. CMAs may create their own form, ensuring that the elements identified in rule are on the required form. Forms must be submitted to the ODM contract manager for prior approval before using.

**E-6: Post-Hospital Home Health and Private Duty Nursing Benefits**

Post-hospital benefits are available to all Medicaid state-plan recipients for no more than 60 days after discharge. To be eligible, an individual on a waiver program must have had three consecutive overnight in-patient stays in a hospital and meet the eligibility requirements as defined in Ohio Administrative Code rules 5160-12-01 and 5160-12-02.

Prior authorization is not required when an individual qualifies for and requires post-hospital home health and/or post-hospital Private Duty Nursing services, due to the temporary availability of the service. However, the CMA cannot authorize continuance of post- hospital services beyond 60 days or in an amount above the currently assessed need unless there is a significant change in condition.

**E-7: Hospice Services**

If an individual elects the hospice benefit, the CMA must update the Person-Centered Services Plan to identify which services will be provided by the waiver and which will be provided by hospice. Once an individual elects hospice services, the hospice provider will provide nutritional counseling, out-of-home respite, durable medical equipment, and social work, as well as home health aide and nursing, therapy, and private duty nursing related to a terminal condition. Waiver services can remain in place and may be increased only if the need is unrelated to the condition for which hospice has been elected.

**E-8: HOME Choice Program**

HOME Choice is part of the Federal Grant Program known as Money Follows the Person (MFP). It is a transition program that assists persons 18 and older with any type of disability to move

from a long-term care facility (e.g. a nursing facility, hospital, or intermediate care facility) into a home and community-based setting.

To be eligible for the HOME Choice program, an individual must:

- Reside in a long-term care setting for at least ninety days
- Have active Medicaid
- Have income or means of support in the community
- Agree to move into an acceptable home and community based setting upon discharge
-

Individuals accepted to work with the HOME Choice program collaborate with the transition coordinators and the other members of the discharge planning team to coordinate and execute a discharge plan. The discharge planning team should include the following: the participant/guardian, transition coordinator, the facility social worker/discharge planner, the CMA (Case Management Agency) worker, the participant's involved family members and other professionals as needs require. The HOME Choice transition coordinators are primarily responsible for the following:

- Identifying and evaluating community living options,
- Creating a sustainable budget,
- Securing affordable housing, if needed,
- Coordinating the use of Community Transitions services (the goods and services fund),
- Arranging community benefits and services, and
- Assisting with move-in activities.

To ensure a successful community transition, a well-developed discharge plan is essential. The plan is developed through one or more discharge planning meetings with all members of the discharge planning team receiving assignments to ensure services are ready to begin on the date of discharge. In addition to transition coordination, community transition services (CTS) or goods and services are available to help the individual set up their new home in the community. These funds are available as a waiver service for those individuals moving out of the facility on a waiver, and available through state funds if the individual moves out of the facility without a waiver program. The transition coordinator, follows the individual for the first 30-days to enhance sustainability and community integration.

A waiver assessment for a HOME Choice individual will be completed by the CMA upon identification by the HOME Choice assessor if an individual appears to be waiver eligible. These waiver assessments will be initiated through the completion of a LTSSQ. The outcome of the waiver assessment will be communicated to HOME Choice Operations by the CMA for the purposes of linking the CMA to the Transition Coordinator (TC), if applicable. Assessment outcome notifications should be sent to: home_choice@medicaid.ohio.gov. See Appendix D of this Guide for additional detail on the role of the Home Choice TC and coordination of Community Transition Services.

# F. Person-Centered Planning & Service Delivery

**F-1: Overview**

Individuals have choice and control over the provision of waiver services they need as determined during the Person-Centered Services Planning process. Individuals also have choice and control over who participates in the Person-Centered Services Planning process, as well as over the selection and direction of waiver service providers. Services and supports are planned and implemented in accordance with each individual's unique needs, expressed preferences and decisions concerning his/her life in the community.

Individuals and/or their authorized representatives participate in, and wherever possible lead the person-centered planning process, participate in the development of the plan and/or select and dismiss ODM-administered waiver service providers. The individual’s authorized representative may have a participatory role, as needed and as defined by the individual, unless Ohio law confers decision-making authority to a legal representative (i.e., a legal guardian).

The person-centered planning process:

- Includes a team of people chosen by the individual.
- Provides necessary information and support to ensure the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the individual.
- Reflects the cultural considerations of the individual. The process is conducted by providing information in plain language and in a manner that is accessible to persons with disabilities and persons who have limited English proficiency (LEP).
- Includes strategies for solving conflict or disagreement within the process.
- Ensures that providers of Ohio Home Care Waiver services for the individual, or those who have an interest in, or are employed by an Ohio Home Care Waiver service provider, shall not provide case management, provider oversight, or develop the Person-Centered Services Plan.
- Offers informed choices to the individual regarding the services and supports the individual receives and from whom.

• Includes a method for the individual to request updates to the plan as needed. The individual may request a Person-Centered Services Plan review at any time.

• Records the alternative HCBS settings that were considered by the individual.

Providers include traditional agency providers such as Medicare-certified HHAs, Joint Commission-, ACHC- and CHAP-accredited agencies, and otherwise approved ODM-administered waiver service providers. They also include non-traditional, non-agency (independent) providers such as RNs, LPNs at the direction of an RN, non-legally responsible family members, and other non-agency providers approved by ODM.

Non-Agency (Independent) Providers
*The CMA must ensure the health and welfare of the individual, and the competency of the individual/representative if an individual elects to receive all or a portion of waiver services from non-agency providers. The CMA must verify that the individual/representative can successfully demonstrate the ability to communicate an understanding of their health care needs, advocate on their own behalf, report provider performance issues, complaints and/or problems to the CMA and/or ODM, and understand and implement problem-solving techniques to resolve conflicts with non-agency providers.

*If an individual and/or authorized representative elects to receive all or a portion of their waiver services from non-agency providers, the CMA must ensure the individual/representative:
- trains the provider(s) to meet the individual's health care needs;
- specifies additional training the provider must successfully complete prior to furnishing waiver services;
- establishes a CMA-approved back-up plan to be followed when the provider is unable to furnish services at the scheduled time and location; and
- approves timesheets after waiver services have been furnished, and prior to the provider's submission of a claim to ODM.

*If an individual elects to receive services from a non-agency provider, but the CMA determines the individual/representative *cannot* successfully demonstrate the skills identified in the preceding paragraph, the CMA may provide or arrange for training in order for the individual/representative to develop those skills. If, upon completion of that training, the CMA still cannot ensure the individual's health and welfare, and the individual’s and/or representative's competency to direct waiver services provided by a non-agency provider, then the CMA may require that the individual only receive services from agency providers.

*Individuals have the right to request a state hearing anytime they disagree with an action that has been taken by a county department of job and family services, a state agency, or the CMA.

**F-2: Person-Centered Services Plan Development Process**

Person-Centered Services Planning under the Ohio Home Care Waiver is a multi-dimensional, participant-centered function that involves the ongoing coordination of Medicaid and other formal and informal supports and services an individual receives. It includes authorizing and arranging for waiver services that support and enhance, but do not replace, what is already furnished by the family and/or informal caregivers. Person-Centered Services Planning addresses the changing circumstances and medical and physical conditions of an individual over time. Inherent in the process is the desired outcome that services and supports are planned and effectively implemented in accordance with each individual's unique needs, and expressed preferences and decisions concerning his or her life in the community. The CMAs are designated by ODM as the entities responsible for Person-Centered Services Planning and ongoing case management. ODM monitors and oversees the CMAs' activities.

Once an individual's waiver eligibility is established, the Case Manager arranges a visit with the individual and anyone else the individual prefers to have present for the development of their person-centered plan. The individual can have as much or as little involvement in the development of his/her Person-Centered Services Plan as he/she prefers.

During the Person-Centered Services Planning process, the CMA reviews the individual's existing informal/formal supports and how they might meet the identified goals, objectives and outcomes. When developing the person-centered service plan, the CMAs will use the "Norms Tool" to determine the type, amount, frequency, scope, and duration of services to meet the individual's needs. The tool should be used at assessments, initial and annual, as well as EBUs that indicate a change in services is necessary. A copy of the completed tool, as well as all updates, must be present in the individual's electronic case record.

The CMA will explore availability of informal/formal supports that can be accessed. Referrals and linkages for supports are established by the CMA to initiate service. The CMA discusses the availability of waiver services to meet the individual's remaining needs after community resources and state plan services are explored, and information is provided to the individual about the broad range of services available under the Ohio Home Care Waiver. The CMA shall explain available service provider options (i.e., they can receive services through traditional agency providers as well as other non-agency providers including RNs/LPNs, neighbors, friends, and non-legally responsible family members).

It is the CMA's responsibility to monitor the individual's Person-Centered Services Plan on an ongoing basis to ensure that all formal/informal, Medicaid and non-Medicaid services are being provided. The plan documents all of the services necessary to prevent the individual's institutionalization, regardless of funding source, as well providers, and the frequency and timeframes for service delivery. It also serves as payment authorization for Ohio Home Care Waiver services.

The Person-Centered Services Plan must:

- Identify and confirm the setting in which the individual resides is chosen by the individual.
- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs as identified through the assessment process.
- Include the individual's identified goals and desired outcomes.
- Identify the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports and those services the individual elects to self-direct.
- Address any risk factors, and measures in place to minimize them.
- Include back-up plans that meet the needs of the individual.
- Be distributed to the individual and other providers involved in the plan.

The CMAs must also ensure the Person-Centered Services Plan is understandable to the individual, and to the people important in supporting him or her. At a minimum, it must be written in a manner that is accessible to persons with disabilities and persons who have limited English proficiency. It must identify the person and/or entity responsible for monitoring the plan. It must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all people and providers responsible for its implementation. Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature must be documented on the plan.

The Person-Centered Services Plan is updated at the time of reassessment, or when events dictate the necessity to reassess individual needs and the appropriateness of the current person-centered service plan, along with the goals and outcomes of the individual.

Individuals are informed whenever there is a proposed change in the Person-Centered Services Plan. They are given notice using ODM-approved forms and are informed of their right to request a state hearing regarding the changes. Similarly, the CMAs are required to notify providers of changes in the individual's Person-Centered Services Plan. The provider can obtain a copy of the Person-Centered Services Plan through the ODM-approved assessment and case management system and the Case Manager may furnish a copy of the updated plan to them upon their request within ten days of when the revised Person-Centered Services Plan is executed.

Individuals work with their Case Manager to make changes to the Person-Centered Services Plan. Changes to the plan that result in a decrease in services, or changes that result in an increase in the cost of services within the individual's funding range are approved by the CMAs. Changes to the plan that result in an increase in the cost of the individual's services in excess of

their funding range are approved by ODM through the prior authorization process described in section E-2 of this guide.

At a minimum, the Person-Centered Services Plan must include: goals, objectives and outcomes; the name, phone number, service responsibilities and funding sources of all paid/unpaid providers and caregivers; the type, amount, frequency, scope and duration of services (including start/stop dates); the total number of approved units of each service and the total projected monthly cost for Ohio Home Care Waiver services and other Medicaid-covered services for a 12-month period; individual-specific emergency back-up plan; patient liability; and the signature of the individual or the individual's authorized representative.

The CMAs must ensure the setting chosen by the individual is integrated in, and supports the full access of individuals receiving Ohio Home Care Waiver services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as people not receiving Ohio Home Care Waiver services.

The CMAs must ensure any modification of the additional conditions required for provider-owned or controlled home and community-based settings are supported by a specific assessed need and are justified in the Person-Centered Services Plan. Documentation in such cases must include the following:

- Identification of a specific and individualized assessed need.
- Documentation of the positive interventions and supports used prior to any modifications to the plan.
- Documentation of less intrusive methods of meeting the need that have been tried, but did not work.
- A clear description of the condition that is directly proportionate to the specific assessed need.
- A regular collection and review of data to measure the ongoing effectiveness of the modification.
- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Informed consent of the individual.
- An assurance that interventions and supports will cause no harm to the individual.

**F-3: Flexibility and Person-Centered Service Plans**

Person-centered service plans (PCSPs) must reflect the needs of the individual, not only regarding services authorized but also with regard to schedule preferences. Service plans must be

descriptive of the type, amount, frequency, scope, and duration of authorized services, yet allow flexibility that accommodates variances with the individual's preferred schedule.

The CMA may write the PCSP in a manner that is not prescriptive of specific start and stop times for hands-on service providers (i.e. Arrival at 1:30pm/Depart at 5:00pm daily). Rather, the CMA may reflect an authorization more generally on the PCSP (i.e. Authorized for 3.5 hours daily to be provided per the individual's scheduling preference), unless an individual has needs that require a specific schedule.

In cases where individuals' unique needs require a service with specific start/stop times, these times must be reflected on the PCSP. For example, if an individual requires the aide to stay with them until school transportation arrives at 7:30am, this must be noted on the PCSP. If the transportation schedule changes resulting in pick up ay 7:45 am, the PCSP must be updated to reflect the change in need. The PCSP will need to be updated when there are variances to specific scheduled that exceed a threshold of 15 minutes of the actual start/stop time.

*The CM may take the following approach when authorizing a service for an individual who utilizes multiple providers.

- The CM and individual should discuss the need for monthly schedules that will reflect how the individual anticipates to schedule and staff the hours of services authorized.
- The CM needs to obtain this schedule from the individual, authorized representative, or provider no later the last business day of the month preceding the month the schedule takes effect.
- The CM will update the PCSP based on this calendar and obtain signatures from all providers. The providers, with oversight from the individual, will then be responsible to document any changes to that calendar (change in visit times, different provider covered visit than originally scheduled, etc.) and provide the revised calendar to the CM no later than the third day of the following month.
- The CM will have two business days to update the PCSP, sending out to all providers for signature.

- The CM must document this approach and signature requirements within the individual's PCSP at least annually.
- The CM may utilize support staff to assist with sending reminders for schedules, gathering schedules, etc. when necessary and appropriate.
- Support staff must not complete work within an individual's case record where that work would be considered a case manager function (i.e. creating PCSPs).

**F-4: Informed Choice of Providers**

The CMAs must maintain an electronic listing of all available agency and non-agency Medicaid service providers, by county and by the service they are authorized to provide. That information is shared with individuals at the time of person-centered service planning, electronically and/or via hard copy, and the individual's choice of providers is respected and considered. The CMAs

also maintain an active and private listing of individuals who are seeking particular types of providers. If the individual wants to hire a friend, neighbor, or non-legally responsible family member as a non-agency provider, they are encouraged to direct the potential service provider to ODM to help them enroll as a Medicaid provider.

**F-4(a): Legally Responsible Family Members as Paid Providers**

Per CMS guidance, a legally responsible individual is any person who has a duty under State law to care for another person. Under the Ohio Home Care Waiver, a legally responsible family member is defined in OAC 5160-45-01 (EE) as an individual's spouse, or in the case of a minor, the individual's birth or adoptive parent. The Ohio Home Care Waiver expressly prohibits payment to legally responsible family members for the provision of personal care and home care attendant services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of an individual. The waiver also prohibits a legally responsible family member from providing waiver nursing, unless the family member is employed by an agency and is supervised.

**F-4(b): Non-Legally Responsible Family Members as Paid Providers**

Ohio Administrative Code Chapters 5160-44, 5160-45 and 5160-46 allow individuals to receive certain services **from non-legally responsible family members** in support of individual choice and control. Specifically, they can provide personal care aide services, waiver nursing, home modification services and supplemental transportation services if they meet provider requirements for the specific service.

The case manager, in consultation with the individual and other members of the individual's team, is responsible for determining whether it is appropriate for a legal guardian to serve as an individual's paid provider. The case manager should first determine if the provider arrangement is permissible in accordance with OAC Chapters 5160-44, 5160-45 and 5160-46 governing the service to be furnished, and the guardianship requirements set forth in either OAC rule 5160-44-31 or OAC rule 5160-45-10, depending on the service. The case manager should also determine whether such an arrangement is in the best interests of the individual, and whether it has the potential to create a conflict of interest for the legal guardian. If it might, alternatives and/or other safeguards may be explored and incorporated into the individual's person-centered service plan.

As a condition of reimbursement, the provider must be identified as the provider, and have specified on the person-centered service plan, the number of hours for which they are authorized to provide the service to the individual. This ensures that payment is made to the non-legally responsible family member as a provider only in return for specific services rendered.

Refer to Appendices E and F of this Case Management Guide for additional information.

**F-5: Backup Plans**

Individual responsibility for back-up planning is explained in the waiver handbook and is supported in ODM's individual rights and responsibilities rule, OAC rule 5160-45-03. Back-up

plans must be documented on the individual's Person-Centered Services Plan. Specifically, the CMAs work with individuals to ensure the existence of back-up plans so as not to jeopardize individual health and welfare if providers do not arrive when expected. Individuals are instructed to immediately call the provider and/or go to their back-up plan. In accordance with the conditions of participation for ODM-administered waiver service providers set forth in OAC rules 5160-44-31 and 5160-45-10, if the provider is employed by an agency, the agency must ensure that a back-up plan is in place and staff are available to provide services when the provider's regularly scheduled staff cannot or do not meet their obligation to provide services to the individual. If the individual receives services from a non-agency provider, the individual must be willing to develop a back-up plan for individual provider absences and emergencies. OAC rules 5160-44-31 and 5160-45-10 also requires the non-agency provider assist the individual, upon initiation of services, in developing a back-up plan in the event the regularly scheduled non-agency provider cannot or does not meet their obligation to provide services.

## F-6: Disaster Planning

The Case Management Contractor must ensure every individual has a disaster plan in place and that it is documented in the Person-Centered Services Plan. The plan must address a fire, tornado, electrical outage and other potential risks that would prevent an individual from receiving services in his or her residence.

## F-7: Services in Schools, Other Day Programs, Vacations, and Travel Planning

The Case Manager must integrate school or other day program services into the Person-Centered Services Plan. The Case Manager may participate as a member of an individual's Individual Education Plan (IEP) team. The Case Manager must also participate in any team meetings with school and/or day programs. Participation may include attending in person, over the phone, via video conference, providing feedback in advance of the meeting, and following up with the team after the meeting to learn of any deliverables or areas identified where the case manager may offer assistance. Documentation must include services, interventions, and/or authorizations developed in relationship to the individual's needs.

Vacation/Travel Planning

The Case Manager must ensure that if an individual is going on vacation or traveling, that a safety plan is in place and documented in the Person-Centered Services Plan. The safety plan must address how the individual's medical needs will be met and how the individual will address medical emergencies. This safety plan must include identifying supply companies or services available in the area where the individuals will be located. Documentation must reflect the planning process and finalized plan developed with the individual and/or authorized representative. The written plan must be included in the individual's case record.

## F-8: Anticipated Increases in Services

The CMA must anticipate increased services during the person-centered service planning process. The CMA and individual must discuss future service needs and plan for those events in the individual's Person-Centered Services Plan.

Examples of events that must be anticipated include, but are not limited to:

- Vacations and respite of informal caregivers
- Scheduled school or workshop breaks and closings
- Scheduled and estimated late start days at school or workshop
- Camp
- Planned hospitalizations of individuals or informal caregivers
- Estimated snow days
- Holidays
- Informal caregiver schedule fluctuations.

Authorizations of services for anticipated events are time-limited as appropriate.

A prior authorization is not required for planning to replace Home Care Attendant services with Nursing when the Home Care Attendant is unavailable. Case Managers do not need to use the prior authorization to develop a back-up plan for an individual using Home Care Attendant. A back-up plan using Nursing is considered anticipated services to replace Home Care Attendant services.

## F-9: Skilled Care and Medical Oversight

Physicians are an integral part of the individual's interdisciplinary team. The CMA must, at a minimum of once per year, identify the physician responsible for medical management of the individual on the waiver. The physician may be the primary care physician or a specialist and must be identified in the Person-Centered Services Plan as the managing physician. The managing physician shall:

- Sign approval on the Person-Centered Services Plan at least annually (when skilled services are not needed or are provided by natural supports), OR
- If the individual requires skilled services and/or has a plan of care, sign approval for the plan of care every 60 days.

The Case Manager must request the plan of care every 60 days from the managing physician and ensure it is uploaded into the clinical record. The Case Manager should also ensure the Person-Centered Services Plan matches the physician's orders, where indicated.

If natural supports are meeting the skilled nursing care needs of the individual, the CMA must ensure medical oversight of the skilled needs is outlined in the Person-Centered Services Plan. This must include assessment by a licensed medical professional at least once every 60 days to ensure the individual's needs are being addressed. If the physician delegates the assessment to a registered nurse, the registered nurse must have physician's orders to perform this service and the service must be designated in the Person-Centered Services Plan.

**F-10: Person-Centered Service Plan Implementation and Monitoring**

The CMAs are responsible for implementing and monitoring the person-centered service plans. Among their primary responsibilities are the following:

- To monitor and ensure individuals can exercise free choice of provider;
- Ongoing involvement to actively engage providers, ensure coverage of all authorized services and shifts, and eliminate gaps in care;
- To monitor and ensure the appropriateness of service delivery and the outcomes identified on the person-centered service plan;
- To monitor and ensure services meet the needs of the individual;
- To monitor and ensure back-up plans are effective;
- To ensure methods are in place for prompt follow-up and remediation of identified problems.

If initiation and delivery of services does not start within 30 days of waiver enrollment, the CMA must complete another face-to-face assessment to ensure the individual continues to meet program eligibility and to review service needs.

**F-11: Acuity Levels**

**New enrollees** on the Ohio Home Care Waiver are assigned an acuity level by the CMA supervisor at the point they have been enrolled for a period of six months. The acuity level is determined based on the individual's needs, complexity of medical issues, available informal supports, and it drives the minimum contact schedule. It is also reviewed at the time of assessment/reassessment and updated based on the individual’s unique circumstances and needs.

**Acuity Level 1** permits no more than 90 calendar days between contacts and no more than 180 calendar days between face-to-face visits. Level 1 case management may be provided to individuals who have been enrolled on the waiver for more than six months and who:

- can safely direct their own care, or live with family or friends who are able to direct their care
- are not isolated from outside resources
- are assessed to be at low risk for health and welfare issues

**Acuity Level 2** permits no more than 30 calendar days between contacts and a minimum of three face-to-face visits in six months with no more than 60 calendar days between visits. Level 2 case management may be provided to individuals assessed to have increased complexity. The intent for this acuity level is to provide increased contacts or visits for individuals who would otherwise be at risk for isolation from outside resources and have an increased risk for health and welfare issues. Without limitation, this includes individuals who:

- Live alone

- Live with a paid provider
- Do not participate in day program, school, or work
- Receive services only from family members or non-agency providers
- Have a restraint, seclusion, or restrictive intervention plan
- Have a Health and Safety Action Plan in effect
- Have been without services, for any reason, for more than 30 days.

Contacts and visits exceeding the minimum required can be made per individual request or based on clinical necessity for either acuity level. During the required contacts, a review of individual outcomes is conducted and the Person-Centered Services Plan is reviewed to determine if services are being rendered as authorized on the Person-Centered Services Plan. Individual satisfaction with services and changes in the individual's health, family and environmental situations are discussed.

**F-12: Contact Schedules**

At six months' enrollment, the Case Manager must meet with the newly enrolled individual to ensure services are meeting his or her needs, update the Person-Centered Services Plan, and ensure the individual's unique funding level is set. The Case Manager must also review the individual's Acuity Level.

| NEW ENROLLEES | | |
|---|---|---|
| **Length of Individual's Enrollment on Waiver** | **Frequency of Contact with Individual** | **Timing of In-Person Visit** |
| 0-1 month | Minimum of two contacts, no more than 14 calendar days between contacts | Within 20 calendar days of the waiver effective date |
| 2-3 months | Monthly | Monthly, maximum of 30 calendar days between visits |
| 4-6 months | Monthly | Minimum of two visits, maximum of 45 calendar days between visits. |

| ACUITY LEVEL 1 | |
|---|---|
| **Frequency of Individual Contact** | **Timing of In-Person Visit** |

| Maximum of 90 calendar days between contacts | Maximum of 180 calendar days between visits |
|---|---|

| ACUITY LEVEL 2 | |
|---|---|
| **Frequency of Individual Contact** | **Timing of In-Person Visit** |
| Maximum of 30 calendar days between contacts | Minimum of three visits in six months,<br>Maximum of 60 calendar days between visits |

# G. Participant Rights

**G-1: Procedures for Offering Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated.

Individuals receive support and guidance from ODM and the CMAs regarding how to exercise their rights and accept personal responsibility. For example, at the time of their enrollment on the Ohio Home Care Waiver, and annually, thereafter, individuals receive relevant ODM publications and a waiver handbook informing them of their right to freely exercise their federal/state statutory rights, including their right to choose HCBS as an alternative to institutional care, and their right to appeal any decision regarding their benefits. Individuals are also informed that if they file appeals in a timely manner (i.e., 15 days after the issuance of the notice) then services will continue during the period of time during which their appeals are under consideration.

ODM leads all hearings related to disenrollment from the Ohio Home Care Waiver. This includes hearings related to waiver disenrollment due to a change in eligibility criteria including level of care. In addition, ODM leads hearings related to service denials that are a result of decisions made by ODM as a result of the prior authorization process.

The CMAs lead hearings related to eligibility denials and service-level denials, including home modifications, supplemental adaptive and assistive device service, and home maintenance and chore service requests, proposed decreases in or discontinuation of services, increases in services

when an individual disagrees, and proposed termination of an individual's option to use non-agency providers. Case management agencies represent ODM in assigned hearings, and must produce and provide copies of an appeal summary to the hearing officer and to the individual on the Ohio Home Care waiver program and his or her authorized representative(s) at least three business days prior to the hearing date.

All case managers shall receive training regarding issuing fair hearing rights and due process procedures during their case management orientation. Case managers' direct role in state hearings is limited, thus preserving their advocacy role with individuals. The CMAs have a hearing manager who provides ongoing technical assistance to case management staff as needed. Notices of adverse actions and the opportunity to request a fair hearing are kept at the designated CMAs and are maintained in the ODM-approved assessment and case management system.

**G-1(a) Requesting an Assistant Attorney General for a Hearing**

When the CMA is notified an individual will have legal representation, the CMA must request an Assistant Attorney General to represent the CMA at the hearing. However, the Attorney General’s office will provide an Assistant Attorney General *only* if the CMA can confirm that the appellant has legal representation.

- All requests for Attorney General representation must be made as directed by ODM. If the request is received fewer than 24 hours before the hearing is scheduled, but at least 30 minutes before the hearing, the Case Management Contractor can e-mail a request for an Assistant Attorney General to attend the hearing. An Assistant Attorney General cannot be requested with a phone call.
- The CMA will be notified of the name of the Assistant Attorney General assigned to the hearing.
- If the Assistant Attorney General is requested fewer than 30 minutes prior to the start of a hearing, or if the request for an Assistant Attorney General is denied or otherwise cannot be fulfilled, the CMA must proceed without Assistant Attorney General representation.

**G-1(b) Hearings Process**

If an Assistant Attorney General is attending the hearing, the Ohio Department of Medicaid or CMA, depending upon who is leading the hearing, must forward all documents pertaining to the hearing to the assigned Assistant Attorney General. If a hearing has been canceled, ODM or CMA, as appropriate, must notify the Attorney General’s office by e- mail as soon as it learns of the cancellation.

If an appellant appears at the hearing with legal representation without advance notice and their legal representation admits new written information or presents testimony not previously seen or heard by ODM, the CMA or the Assistant Attorney General, and the preceding parties need time to review and consider the new information, they can request the hearing be reconvened or the record left open for the submission of additional documentation. State hearing officers will make the final ruling on whether the hearing will be reconvened or the record left open.

If an appellant has no legal representation and submits new evidence or documentation, not previously reviewed or considered, ODM or CMA may request the hearing officer reconvene the hearing or leave the record open to allow them to review and respond to the new evidence or documentation.

If an appellant has requested a state hearing within 15 days of the CMA having issued an adverse notice containing hearing rights, the CMA must continue the appellant's services at his or her current level until the outcome of the state hearing. When the hearing decision is rendered, the CMA must follow the decision as directed and submit a compliance form to the Ohio Department of Job and Family Services' Bureau of State Hearings validating compliance.

When ODM receives a hearing decision, the decision will be forwarded to the CMA. The CMA is responsible for reading the hearing decision and adhering to the compliance ordered in the decision. The CMA must complete and submit the State Hearing Compliance Form (JFS 4068) to the ODM designee and provide a complete description of the compliance action, including the exact dates the action occurred.

All compliance, in accordance with OAC rule 5101:6-7-03, must be achieved within 15 calendar days of the decision and no later than 90 days from the date of the hearing request. ODM will review the compliance and, if accepted, forward it to the Bureau of State Hearings. If not accepted, the compliance will be returned to the CMA for further action.

If the appellant disagrees with the state hearing decision, he or she may make a written request for an administrative appeal to the Ohio Department of Job and Family Services, Bureau of State Hearings, PO Box 182825, Columbus OH 43218-2825 or fax (614) 728-0874. Their written request must be received by the Bureau of State Hearings within 15 calendar days of the date the hearing decision was issued.

During the administrative appeal process, the CMA must proceed with enacting the state hearing decision unless instructed by the Bureau of State Hearings to do otherwise.

## G-2: Grievance/Complaint System

Individuals are informed by the CMAs of their right to voice dissatisfaction and/or register a complaint any time they feel a Medicaid service provider or the CMA or any of its employees has been unresponsive to their requests, or has been inconsistent in efforts to help the individual reach their home care goals, objectives or desired outcomes. They are also informed that a complaint is not a prerequisite to a fair hearing. This information, including individuals' rights and the process for addressing complaints, is found in the waiver handbook and on the CMAs' websites.

Complaints can be made to the CMA, Provider Oversight Contractor, or to ODM. They can originate from a face-to-face conversation, phone call, email, ODM inquiry, or regular mail. If the CMA receives a complaint about a provider, the complaint must be forwarded to the provider oversight contractor.

The CMAs must use the following protocol for complaints:

1. Categorize complaints, reference a department, and determine a resolution type.
2. Send a complaint acknowledgment letter to the complainant within one business day of the complaint. A copy of this letter is sent to the ODM contract manager.
3. Investigate all complaints within three business days of the date of receiving the complaint and maintain a record of all investigatory notes.
4. Submit an action plan to the ODM contract manager via email within seven days of receiving the complaint.
5. Address and attempt to resolve all complaints within 15 calendar days and record the resolution.
6. The CMA must send a follow-up letter to each complainant to confirm that resolution has taken place. A copy of this letter is sent to the contract manager.
7. If a complainant indicates to ODM that a satisfactory resolution was not obtained, and ODM agrees, the complaint will be re-opened and returned to the CMA for further investigation. (Return to Step 3 of this process)

In addition, an individual may contact ODM at any time to register a complaint. Individuals also have the ability to contact the ODM Ohio Medicaid Hotline. These calls are referred to the ODM contract managers.

# H. Participant Safeguards

**H-1: Risk Assessment and Mitigation**

Risk and safety considerations are assessed on an ongoing basis, and with the informed involvement of the individual, potential interventions that promote independence and safety are considered. During assessments, reassessments, and anytime thereafter, any known or perceived risk and/or safety considerations are documented on the person-centered service plan and in clinical documentation. The CMAs may initiate risk and safety planning via the implementation of a "Health and Safety Action Plan" form, or explore development of a behavior support plan by appropriate personnel.

**H-2: Health and Safety Action Plan**

When the individual's actions or inaction pose or continue to pose a risk to his or her health and welfare, the CMA must develop and implement a Health and Safety Action Plan (HSAP). The HSAPis created between the CMA and the individual and/or the legal guardian, as applicable, identifying the risks and setting forth interventions recommended by the CMA to remedy risks to the individual's health and welfare.

**H-2(a): Health and Safety Action Plan (HSAP) Required Components:**

- Identification of the health, safety, or welfare concern(s). If more than one concern is identified, the program may make the determination to either include all the risks in the same form or use separate forms.
- Description of the possible consequences of not resolving the identified concern(s).
- Outline of the recommended action steps including clear and measurable goals and implementation time frame.
- Description of the Case Manager/Waiver Service Coordinator/Recovery Manager/PACE Social Worker role including:
    - How he/she will monitor the individual's progress.
    - How he/she will collaborate with the individual the team members responsible for the authorization of services, and the team members responsible for the provision of authorized services to ensure the individual's safety.
- Signature of the individual/legal guardian (or notation they have declined to sign).
    - Required upon initiation of the plan.
- Signature of staff implementing the HSAP (e.g., case manager, waiver service coordinator, recovery manager/PACE Social Worker) indicating that the individual has been fully informed and provided with an opportunity for review/response.
    - Required upon initiation of the plan.

The HSAP must be identified in the Person-Centered Services Plan. The HSAP form must be used when developing the plan and it must be monitored *monthly* to ensure the individual is adhering to the proposed interventions, as well as to ensure there is follow up on recommendations for service linkage, etc. Case file documentation must address how the individual is progressing with the agreed-upon interventions, progress toward goals (positive and negative), and modifications to interventions based on assessment of progress. If the individual has followed the plan and is no longer considered a risk, then the plan can be discontinued. Discontinuation of the plan must be clearly documented in the clinical record and the HSAP form should be updated as closed.

The HSAP must:

• Be in writing and uploaded into the individual's record in the ODM-approved assessment and case management system.

• Be documented in the Person-Centered Services Plan.

• Be reviewed with the individual and updated accordingly.

• Be monitored during visits, team meetings, and plan updates to determine progress toward achieving the desired outcomes. Monitoring must be documented *monthly* in the communication notes in the ODM-approved assessment and case management system.

Action must be taken if the identified risks continue and/or cannot be mitigated. The CMA must document all monitoring, including interventions that prove successful, as well as action steps that are not successful and do not mitigate identified risks.

**H-2(b): Disenrollment Due to Inability to Ensure Health and Welfare**

If the individual does not adhere to the agreed-upon interventions, and the case manager advises the individual's health and welfare cannot be ensured, the CMA may submit a recommendation to ODM's Ohio Home Care Waiver Clinical Manager, or their designee, to disenroll the individual from the waiver due to the inability to ensure his or her health and welfare. This may be done as soon as continued risks without any resolution are identified or after intervention attempts have failed. The HSAP must be in place at least one month before a recommendation to disenroll is submitted to the Ohio Home Care Waiver Clinical Manager or their designee.

The clinical record must demonstrate the lack of progression towards established interventions. This should include if the individual has declined to participate in interventions and all actions the case manager has taken to support the individual in reducing risk. The HSAP or any additional supporting documentation must be provided at the time of the request. It is essential that the CMA clearly identifies what interventions, resources, referrals and collaborations have been conducted to support successful outcomes for the individual. At minimum the follow components should be provided when requesting disenrollment:

- **Reason for Request**
  - Provide a summary the concerns that have led to requesting disenrollment.
- **Individual Summary**
  - This should include information about the individual such as name, age, where they live, how long they have been enrolled in OHCW and medical history.
- **Services**
  - If there is an issue with an individual not having providers or access to needed services, this should also be addressed. The CMA should indicate when and who they reached out to in order to identify providers**.**
- **HSAP**
  - Include a copy of the latest HSAP and provide a summary of the when the HSAP was developed, changes or amendments and the status of the current HSAP. Specific dates are required.
- **Interdisciplinary Team Meetings**
  - Summarize team meetings and collaboration activities. Include dates and who was involved.
- **Incident Reports**
  - Summarize and incidents reports submitted associated with presenting issues.
- **Resources and Referrals**
  - Summarize including names, dates and reasons for referrals and resources provided to the individual. In addition, provide the results of the resources and referrals provided including if the individual declines the information.
- **Medicaid Eligibility**

    - Indicate if the individual will or will not be eligible for Medicaid without the OHCW enrollment.
- **Transition Plan**
    - Develop and explain the transition plan that will be in place if approval is granted to initiate the disenrollment process. This should include identifying how loss of waiver services will be addressed.
- **Clinical Director Statement**
    - Prior to submitting a disenrollment request to ODM the CMA should complete a through internal review and provide a statement from the clinical director supporting the request for disenrollment.

Requests received by ODM will undergo review by the interdisciplinary clinical team and a written response will be issued to the CMA. If a concern expressed in the request is not addressed in the HSAP, it will be returned to the CMA and the CMA will be asked that it be added and monitored for at least one month. ODM responses may include a request for additional follow up action(s) or a recommendation to proceed with notice of disenrollment due to an inability to ensure health and welfare.

## H-3: Behavioral Interventions: Restraint & Restrictive Intervention

Restraint

Restraint is used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Allowable restraints include:

• Physical restraint, i.e., the use of any hands-on or physical method to restrict the movement or function of the individual's head, neck, torso, one or more limbs or the entire body; or

• Chemical restraint, i.e., the use of any sedative psychotropic drug exclusively to manage or control behavior; or

• Mechanical restraint, i.e., the use of any device to restrict an individual's movement or function for any purpose other than positioning and/or alignment.

Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restraints. They will always be explored and encouraged by the CMAs and the individual's team.

Restraints may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. The only restraint that may be used in an emergency is a protective hold, which is the application of body pressure to an individual for the purpose of restricting or suppressing the person's movement. Any other use of prone restraints is prohibited.

The following are not considered restraints:

• Any device that an individual can remove or is used for positioning and/or alignment

• Age-appropriate devices such as a crib, playpen, or child-gate to safeguard babies or toddlers or age-appropriate child safety seats used in a vehicle;

• Physical guidance or assistance to complete ADLs or medical procedures, or for safety, such as holding hands when crossing the street if not age-appropriate

• Medication ordered to be used in preparation for a medically necessary medical procedure.

Restrictive Interventions

Restrictive interventions are used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of restrictive interventions. They will always be explored and encouraged by the CMA and the individual's team.

Restrictive interventions may be appropriate to address issues such as wandering in unsafe environments, risk of ingesting unsafe or unhealthy items or failing to complete necessary medical/personal care tasks. Interventions may include, but are not limited to manipulation of the environment or denying access to a wanted item or activity until completion of a certain task. Restrictive intervention may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience.

Time away is a restrictive intervention during which the individual is directed away from a location or an activity using verbal prompting, only to address a specific behavior. The individual is able to return to the location or activity at his/her choosing. Time away shall never include the use of a physical prompt or an escort. Time away is considered a restrictive intervention as long as the intervention does not meet the definition of seclusion/time-out. The use of any physical prompt or required timeline for re-engaging in an activity shall elevate the restrictive intervention to "seclusion."

Seclusion

Seclusion is used for behaviors that pose a serious risk of harm to the individual or to others. Such behaviors include, but are not limited to, aggression to others, objects, or self. Less restrictive measures such as verbal redirection/prompting and positive reinforcement are alternative strategies to avoid or reduce the use of seclusion. They will always be explored and encouraged by the CMAs and the individual's team.

Seclusion or Time Out is any restriction that is used to address a specified behavior that prevents the individual from leaving a location for any period of time. Seclusion may include preventing the individual from leaving an area until he or she is calm. Seclusion shall never include the use of locked doors and must always include constant visual supervision of the individual. It must only be used for behaviors that are physically harmful to the individual or other persons.

Seclusion may not be used as a routine programmatic intervention, for punitive purposes or for staff convenience. Time-out or seclusion will only be permitted if approved as a part of a behavior support plan.

Behavior Support Plans for Restraint, Restrictive Intervention and Seclusion:

If it is determined through the assessment and person-centered services planning processes that restraint, restrictive intervention, and/or seclusion are being considered by the individual's team, the CMA will work with the team to promote the least restrictive/intrusive, most positive intervention culture needed to keep the individual safe. Restraint, restrictive interventions, and seclusion must be authorized pursuant to a behavior support plan developed by a physician, licensed psychologist, county board of developmental disabilities, or another behavioral health treatment professional, in conjunction with the CMA and the individual's team. Only physicians can authorize chemical restraints. Only a county board of developmental disabilities (CBDD) can authorize the use of seclusion. The behavior support plan is an addendum to the person-centered service plan. Staff who are implementing restraint, restrictive interventions, and/or seclusion will be trained via a variety of methods including, but not limited to, training directly from the entity that is writing the plan.

The following are prohibited:

• Use of seclusion that is not a part of a plan authorized and overseen by a CBDD.

• Use of prone (face-down) restraint if prohibited by an authorizing entity.

When a plan for restraint, restrictive intervention, and/or seclusion is being developed, the CMA must ensure that the following elements are addressed:

• Agreement from the individual's team that the use of intervention(s) is appropriate.

• Promotion of the least restrictive/intrusive intervention, and the most positive intervention culture needed to keep the individual safe.

• Inclusion and requirement of the use of preventive and/or alternative measures to ensure the safety and well-being of the individual.

• Verification of authorization of the use of the intervention(s) by the authorizing entity.

• Identification of an oversight entity responsible for ensuring that staff are appropriately trained regarding implementation of the behavior plan, including use of the intervention(s), as well as for ongoing monitoring of the use of the intervention(s). The oversight entity can include a parent/guardian or authorized representative or a behavioral health provider. However, the person implementing the intervention(s) cannot be the person responsible for monitoring the use of the intervention(s).

• Existence of a plan to ensure, and identification of the party responsible for, training the staff who implement the intervention(s).

• Documentation of the planned use of intervention(s) in the individual's Person-Centered Services Plan and communication record.

Any use of the approved restraint, restrictive intervention, or seclusion must be documented by the provider and reviewed by the case manager during routine visits and team meetings. Any use of a restraint, restrictive intervention, or seclusion that is not approved or is implemented contrary to the plan must be reported as an incident via the ODM-approved assessment and case management system. The provider must contact the CMA. The CMA must contact the individual and his/her legal representatives within 24 hours of receiving the incident report. Changes to the Person-Centered Services Plan or living situation may be considered to support the person’s safety and well-being. Follow-up visits in response to the incident report and to complaints by the individual and his/her legal representatives will be conducted and include questions about any actions taken by the service provider that may qualify as unauthorized use or misapplication of a restraint, restrictive intervention, or seclusion.

Individuals who are also receiving services through a CBDD are eligible to access services through a behavior support plan. This includes the county board’s oversight committees and processes. CMAs are expected to collaborate with county board staff to access this service on behalf of the individual. CMAs should request to be added specifically to the list of those who receive status reports for individuals with an aversive plan, which would include those plans with restraint, restrictive intervention, and/or seclusion.

Restraint, Restrictive Intervention, and Seclusion Oversight:

The CMAs report data to ODM on a quarterly basis regarding such things as the number of individuals for whom restraint, restrictive interventions, and/or seclusion are used; types of restraint, restrictive interventions, and/or seclusion being used; and authorizing entity.

The CMA will identify any unauthorized or inappropriate use of restraint, restrictive interventions, and/or seclusion and report case specific information through the incident management system. The provider oversight contractor will report this data to ODM. Data is analyzed by both the provider oversight contractor and ODM, with appropriate follow-up as needed regarding identified trends and patterns to support improvement strategies.

Follow-up includes, but is not limited to: additional ODM or provider oversight contractor training of CMA or provider staff, and/or changes in protocols and/or rules. Through this analysis and the incident management system, if case-specific concerns are noted, follow-up will occur with the authorizing entity and the individual's team.

Any significant injuries which result from employment of restraint, restrictive interventions, and/or seclusion must be carefully analyzed and immediately reported to ODM and the CMA in accordance with critical incident reporting requirements.

In addition, the CMA and an oversight entity (e.g., a parent/guardian or authorized representative or a behavioral health provider) will help to ensure that staff is appropriately trained and that restraint, restrictive interventions, and/or seclusion is used safely and appropriately. The provider oversight contractor must communicate with the case manager and verify documentation of the

use of restraint, restrictive interventions, and/or seclusion in the person-centered services plan, and communication record.

The CMAs must develop an individual-specific annual report that will be sent to the physician who certified the plan if the physician is the authorizing entity. The report must include identification of the restraint, restrictive interventions, and/or seclusion used, frequency of use per month, and information regarding the outcome or response to the use of the restraint, restrictive interventions, and/or seclusion. The CMAs must ensure the physician reauthorizes the use of the restraint, restrictive interventions, and/or seclusion at least annually.

The CMAs must review status reports for approved plans at least monthly. This must include addressing any implementation concerns and assuring unauthorized restraint, restrictive interventions, and/or seclusion have been reported appropriately. The CMAs must review and discuss the use of restraint, restrictive interventions, and/or seclusion with the individual's team on an ongoing basis, and at least every 90 days. Additionally, the CMAs must review all incidents related to the use of restraint, restrictive interventions, and/or seclusion. They must also review the use of all restraint, restrictive interventions, and/or seclusion to ensure the use was appropriate and within prescribed guidelines.

Use of any unauthorized restraint, restrictive interventions, and/or seclusion is reported to the CMAs as an incident. Additionally, the use of any prohibited restraint, restrictive interventions, and/or seclusion is reported as an incident. Case managers are required to review these expectations with all persons authorizing and implementing a restraint, restrictive interventions, and/or seclusion.

**H-4: Service Monitoring**

The CMA must monitor service delivery ongoing. Monitoring services is not a compliance review process, but rather a quality check to ensure the health and welfare of the individual, as well as to ensure all needs are being met. At any time, if there are concerns about the individual's well-being, including incident identification, or about the performance of the provider, the CMA must follow incident reporting guidelines.

Service Monitoring includes:

- Confirming the start of services within one business day of a new service or a new provider being added to a Person-Centered Services Plan.
- Monitoring provider service delivery by reviewing notes, plans of care, and other documentation submitted, or present in the home, to ensure services are delivered according to the type, amount, frequency, scope and duration reflected on the Person-Centered Services Plan. This includes comparing plans of care to the Person-Centered Services Plan to identify changes and consistency. Any changes made to the plan of care that were not previously reported to the CMA must be assessed to determine the need for an event-based assessment and/or incident report, as applicable.

- At minimum, the CMA must include documentation of service monitoring activities in conjunction with contacts and visits conducted as part of the contact schedule.

- Documentation of service monitoring activities conducted by the CMA must reflect a confirmation the CMA reviewed whether services are delivered according to the type, amount, frequency, scope and duration reflected on the person-centered services plan.
  - Documentation in the case record must reflect follow up actions taken by the CMA when it is identified that services are not being provided as documented in the person-centered service plan.

**H-5: Transition Planning**

The Contractor is responsible for collaborating with acute and long term care providers (including, but not limited to hospitals and nursing facilities) on discharge and transition planning for individuals returning to the community. Collaboration includes, but is not limited to, outreaching the facility upon notification of an inpatient admission or observation, participating in the development of the discharge plan, requesting a copy of the discharge plan, and following up to ensure delivery of post-discharge services in order to avoid gaps in care.

The case manager is responsible for transition planning when it becomes known an individual will transition from the Ohio Home Care Waiver, or if Ohio Home Care Waiver disenrollment is pending. Transition planning includes, but is not limited to, making referrals to community resources and verifying continuation of state plan services prior to the disenrollment date.

When transitioning to another waiver or care management arrangement, collaboration and communication with the receiving entity is the expectation. If the individual is transitioning to another HCBS waiver, the most recent assessment and care plan information should be provided to the waiver entity that will be assuming responsibility for meeting the needs of the individual going forward. For individuals enrolled in managed care plans (MCPs), the CMA must outreach and work with the MCPs to ensure post-transition needs will be met.

When transitioning from OHCW to PASSPORT, the individual must transition to PASSPORT following their 60$^{th}$ birthday, but no later than the individual's annual redetermination due date following their 60th birthday.

- Six months prior to an individual's transition to PASSPORT
  - The CMA must initiate the transition conversation with the individual.
  - Discuss whether the individual is interested in transitioning current independent providers, if applicable, to become an Ohio Department of Aging certified provider and the potential timeline for this process.
  - The CM will assist in linking the individual's independent providers with the Ohio Department of Aging for provider enrollment assistance.
- Ninety days prior to an individual's transition to PASSPORT

- The CMA must track individuals who are 59 years-old and have a plan in place to ensure smooth transitions.

All individuals will be provided with fair hearing rights prior to waiver disenrollment, and at no time should allowing for due process stop the transition planning process. The case manager will continue to work with the individual/authorized representative until the hearing outcome is received. If the hearing decision results in maintaining enrollment in the Ohio Home Care Waiver, then case management will continue. If the decision is to disenroll, then the disenrollment process must proceed. The individual/authorized representative must be fully aware of what will occur if the decision to disenroll from the Ohio Home Care Waiver is upheld and this must be documented in the communication record.

## H-6: Incident Management

ODM, the CMAs, the provider oversight contractor and all service providers must ensure the health and welfare of the individuals to whom they provide Ohio Home Care Waiver services. All waiver service providers, case managers and employees of home health agencies are required to report incidents in accordance with applicable Ohio Administrative Code rules, including OAC rule 5160-45-05 governing incident management under the Ohio Home Care Waiver, and as outlined in this section. The CMA shall report to the ODM-delegated provider oversight entity any discovery of provider non-compliance with the provider conditions of participation outlined in rule 5160-45-10 of the Administrative Code. The CMA must comply with that rule and follow the protocol below when an incident occurs:

1. Take Immediate Action

   - Upon discovery of an incident or allegation, the CMA must take immediate action(s) to ensure the health and welfare of the individual.
   - Verify that the county coroner was notified in the event of the death of a member when the person died as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, or died suddenly when in apparent good health, or when the member had a developmental disability regardless of the circumstances, and in accordance with section 313.12 of the Revised Code. If such action was not taken, the CMA or the provider oversight contractor must do so immediately.

2. Report to Protective Agencies

   - Immediately after securing the individual's safety, the CMA must notify law enforcement, county children's services, adult protective services, CBDD or other entity, as appropriate. ODM also requires the CMA to cooperate with these entities, as needed, in investigations.

3. Report Incident(s) to ODM via the ODM approved Incident Management System (IMS). Please see the IMS Manual for details on how to submit an incident report and prevention plans.

- The CMA must report incidents in the incident management system (IMS) within 24 hours of the CMA discovery.
- Critical Incidents
  - All critical incidents as defined in incident rule 5160-44-05 will require an investigation by the provider oversight contractor. Once an investigation is completed and substantiated the CMA will be required to develop a prevention plan. The prevention plan will then be added to the IMS as well as to the individuals Person-Centered Services plan within 15 calendar days.
- Reportable Incidents
  - All reportable incidents as defined in incident rule 5160-44-05 will be entered by the case management agency as well as addressed by the CMA. The Provider Oversight Contactor will not investigate these incidents. It is the responsibility of the CMA to close each of these cases and close the reportable incident within 30 calendar days.

| **Critical Incidents** | **Reportable Incidents** |
| --- | --- |
| Abuse | Death |
| Neglect | Individual or family behavior, action or inactive resulting in the creation of, or adjustment to, a health and safety action plan |
| Exploitation | The health and welfare of the individual is at risk due to the loss of the individual's caregiver |
| Misappropriation | Any of the following prescribed medication issues:<br>• Individual misuse not resulting in EMS response, emergency room visit or hospitalization<br>• Individual repeated refusal to take prescribed medications not resulting in EMS response, emergency room visit, or hospitalization |
| Unexplained death | Hospitalization that resulting in an adjustment to the person-centered services plan |
| Health and Welfare at risk:<br>• Activities involving law enforcement intervention<br>• The individual's health and welfare is in immediate and serious jeopardy<br>• An unexpected crisis in the individual's family or environment resulting in an inability to ensure | Eviction from place of residence |

| | |
|---|---|
| the individual's health and welfare in his or her residence<br>• The individual cannot be located, is lost or wandering | |
| Prescribed medication issues:<br>• Provider error<br>• Individual's misuse resulting in EMS response, emergency room visits or hospitalization<br>• Individual's repeated refusal to take a prescribed drug resulting in EMS response, emergency room visit or hospitalization | |

- Provider Occurrences

  CMAs are required to report any issues they are aware of concerning the actions or performance of the provider that put the health and safety at risk or harm or violate the provider conditions of participation as follows:

| **Provider Occurrences** | |
|---|---|
| Provider engaged in behavior that compromised the health and welfare of the individual | Sex while on the clock |
| Services delivered without or not in accordance with physician's orders | Sleeping on the job |
| Breach of confidentiality | Took individual to provider's place of residence |
| Designated to serve or make decisions for individual | Unprofessional behavior that interferes with delivery of services |
| Failure to activate the back-up plan in case of emergency or unplanned absence | Unprofessional behavior towards the individual |
| Failure to comply with provider specs | Billing for services not rendered |
| Failure to cooperate with investigation | Falsified documentation/Physician's orders |
| Failure to deliver services professionally, respectfully, and legally | Falsified the individual's signature |
| Failure to ensure individuals are protected | Inappropriate billing |
| Failure to maintain documentation | Kickback to/from consumer |
| Failure to notify required people when unable to provide services | Subcontracting Service |
| Failure to report an incident | Submitted claim while the individual was institutionalized |
| Insufficient monitoring by RN | Sex while on the clock |
| Medication administration errors | Sleeping on the job |

| Services not in accordance to the service plan | Took individual to provider's place of residence |
|---|---|
| Services provided beyond the provider's scope of practice | Unprofessional behavior that interferes with delivery of services |

- Potential CMA involvement: If, at any time, during the discovery or investigation stages, information surfaces that indicates that a CMA employee is directly or indirectly responsible for the **death, abuse, exploitation, misappropriation, or neglect** of an individual, the CMA must immediately notify ODM, which will assume the investigation.

- Incident Prevention Planning: After the critical incident investigation is concluded and substantiatedthe CMA must create a prevention plan to prevent the same or similar incident from reoccurring and submit it in IMS.

  Prevention planning must include an evaluation to determine how to mitigate the effects of the occurrence, how to eliminate the risk to the individual from the cause(s) and contributing factors, and/or how to eradicate those cause(s) and contributing factors that pose a continued risk to the individual and others.

  The prevention plan must:
    • Be objective, measurable, attainable, reasonable (include timelines), realistic, enforceable, verifiable, and sustainable
    • Consider and address all cause(s) and contributing factors and effects of the occurrence
    • Be comprehensive and meet appropriate, legal, ethical, industry and profession standards, and be an acceptable practice

Some prevention plan elements may require multiple actions including, but not limited, to:
• Training for other provider and agency staff members
• Revising Person-Centered Services Plans
• Disciplining employees
• Taking administrative actions (i.e., changing policy or procedures, reassigning staff, increasing staff ratios).

The case manager must discuss the prevention plan with the individual prior to adding to the Person-Centered Services Plan and ensure that the individual permits the addition of the prevention plan being added to the Person-Centered Services Plan.

- Closing a reportable incident includes:
  - The CMA should determine what lead to the incident (causes and contributing factors)
  - The CMA should establish measures to prevent the incident from happening in the future.
  - The CMA should document all identify causes and contributing factors of the incident as well as the plan to address mitigating future incidents.

4. Participant Training and Education: Individuals participating in the Ohio Home Care Waiver will receive a waiver handbook from their CMA at the time of enrollment and at the time of reassessment. The handbook will include information about individuals' rights, protections against and how to report alleged incidents. It also contains information about the advocacy agencies that can educate and assist individuals. The CMAs, through the case manager, verbally will review the content of the handbook with individuals/family members/caregivers. They will sign a form that documents receipt of this information at least annually. The signed form is maintained in the ODM-approved assessment and case management system.

The CMAs will provide individual instruction to individuals, caregivers, and authorized representatives about how to notify the authorities in the event health and welfare may be in jeopardy. The CMAs will reinforce the training on incidents during each contact and/or in-person visits. The CMAs will also assist individuals and/or their informal caregivers with any formal notification necessary.

The CMAs will also operate toll-free care management lines where individuals can receive additional information or assistance, if needed. These lines will have the capacity to assist LEP individuals and/or individuals who are hearing impaired.

5. Trend Analysis and Follow Up: Incident reporting will be calculated on a statewide and regional basis. ODM will meet with the CMAs to provide technical assistance for planning and prevention.

If a CMA is found to have deficiencies or systemic issues with incident management, the ODM contract manager will require them to submit a plan of correction to address how they will be corrected.

6. ODM also employs incident managers who monitor incidents. These managers have three responsibilities: to provide oversight of incidents, conduct data analysis of incidents and provide education and training related to incident management.

**H-7: Medication Management and Administration**

The safe, effective and appropriate use of medications is an essential component to the Ohio Home Care Waiver, and to the assurance of the individual's ongoing health and welfare. The CMA will complete a review of the individual's medications and utilization during the assessment/reassessment/ongoing assessment process. This includes all prescription, over-the-counter medications, nutritional supplements and herbal remedies. The person(s) responsible for administering medications will be identified and documented in the comprehensive assessment and on the person-centered services plan.

Administration of medication by agency and non-agency providers will be limited to medical personnel who are professionally licensed to do so in accordance with the Revised Code (e.g., a

physician licensed to practice in the State of Ohio, and a nurse licensed to practice in Ohio in accordance with Section 4723. of the Revised Code, etc.). Providers who are responsible for medication administration will be required to record and report medication administration errors to the CMA for appropriate follow-up and referral (see incident reporting above). Medication errors will be recorded in the ODM-approved assessment and case management system and monitored through the incident management process. When errors are substantiated, referrals will be made to the physician, and when appropriate, the applicable state licensing authority.

Medical professionals who prescribe medication will have “first-line” responsibility for monitoring medication regimens. Ongoing monitoring of medication management will also take place during regular contacts and visits with the case manager.

The Case Manager must refer any individual suspected of prescription drug abuse or misuse to the Coordinated Services Program described in OAC Rule 5160-20-01. Individuals on a Coordinated Services Plan must have a specific plan for monitoring medication use in the Person-Centered Services Plan.

The Case Manager must ensure, in all circumstances when an individual is utilizing prescribed opiates, that there is a specific plan in place to ensure the use of those medications is as ordered. The plan must include at least intermittent monitoring by a medical professional, including the prescribing physician, as well as specific training for non-medical staff on identifying misuse or abuse of medications.

**H-8: Electronic Visit Verification**

ODM operates an Electronic Visit Verification (EVV) system to electronically document services furnished to individuals. Providers of waiver nursing, personal care aide and home care attendant services under the Ohio Home Care Waiver verify service delivery using the EVV system. EVV captures and logs visit data electronically, including the service type, date, visit start and end times, GPS coordinates, and individual verification of the visit, ensuring that individuals receive their medically necessary services. For more information about the EVV system, please contact the EVV Hotline at (855) 805-3505.

**H-9: Individual-to-Case Manager Ratios**

The Ohio Home Care Waiver serves individuals at various levels of case management acuity. To meet the case manager to individual ratio, the CMA shall use the following point system: Level One Acuity individuals are each assigned a 1.66 point value. Level Two Acuity individuals and all new (through first six months of enrollment) enrollees are each assigned 2.22 point value. The total value of points per each case manager caseload shall not exceed 100 points. This point system will allow the CMA to assign mixed caseloads to case managers.

**H-10: Case Manager-to-Clinical Supervisor Ratios**

The CMA must maintain a Case Manager-to-Clinical Supervisor ratio of not more than 12:1. Supervisors must meet with each Case Manager at least once per month to review caseloads, current case assignments, critical issues, etc. The Contractor must maintain documentation of the

monthly Case Manager case load reviews including date, cases reviewed, and follow up actions required of the Case Manager. This documentation must be available at the request of ODM. Supervisors must also hold monthly team meetings with their Case Managers for peer review, reviewing practice standards, etc.

# I. Quality Management Plan

ODM must comply with six federal waiver program assurances in order to maintain approval from the Centers for Medicare and Medicaid Services to operate the waiver program. The Quality Management Plan sets forth requirements imposed on the CMAs in order to guarantee that these assurances are met. The Bureau of Clinical Operations is responsible for the oversight of the Quality Management Plan. Additional detail on the Quality Management Plan can be found in the Ohio Home Care Waiver Program Case Management Request for Proposals.

# J. Accessing Ohio Department of Medicaid's Information Management Systems

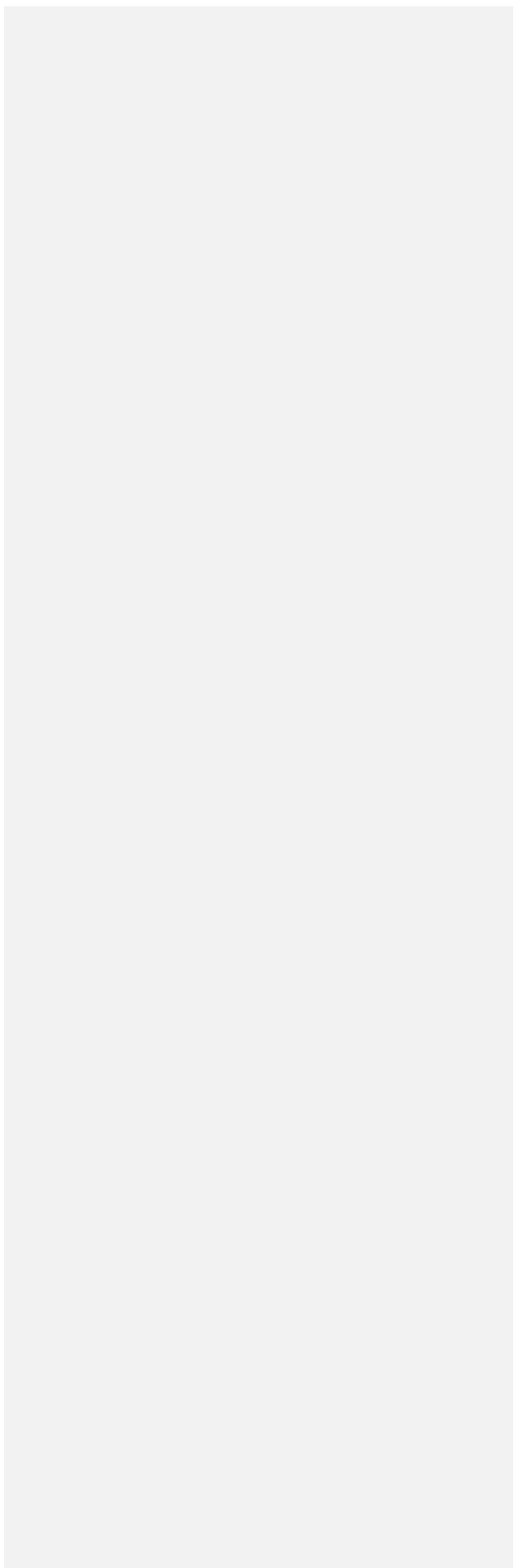
In order to fulfill case management functions, the CMA must have access to state data systems, which requires it to implement a secure virtual private network connection. This must be done in cooperation with ODM.

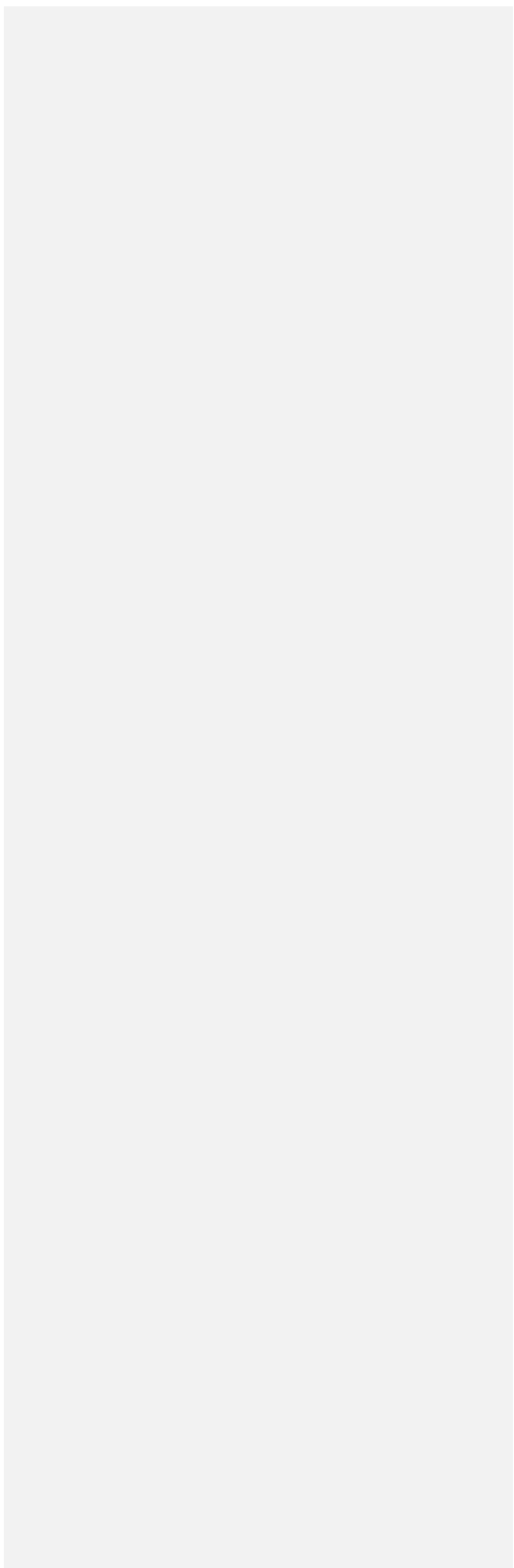
ODM will provide the CMA access to the following ODM data systems:

1. Medicaid Information Technology System (MITS)
2. Ohio Benefits used by ODM and county departments of job and family services
3. Incident Management System (IMS)

The CMA must request new user staff access through ODM by submitting the appropriate access request documentation. The request is made by completing a Code of Responsibility Form (ODM #07078), which can be requested by e-mail to the ODM contract manager(s). Completed forms must be submitted through the CMA's contract manager.

Conversely, the CMA must request termination of ODM system access within one business day of the last date of employment for any user with access to any ODM system. Requests for terminations may be made in advance, and all requests for termination of system access must be submitted through the CMA's contract manager.





# Appendix A

## Supplemental and Adaptive Assistive Devices, and Vehicle Modifications Guidance

### Supplemental Adaptive and Assistive Device Services

"Supplemental Adaptive and Assistive Devices" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. Supplemental adaptive assistive devices and vehicle modifications are subject to the specifications found in OAC rule 5160-46-04.

ODM recognizes that service animals can be beneficial to some individuals with disabilities and supports the use of community resources to acquire and maintain service animals. There are many nonprofit organizations that raise, train, and offer service animals to individuals with disabilities and often do so free of charge or at reduced costs to those who qualify.

Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same individual. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.

The Ohio Home Care Waiver provides medically necessary supplemental adaptive assistive devices, and vehicle modifications. When an individual requests one or more of these, the CMA must:

1. Obtain a denial from any third-party insurance available and Medicaid fee-for-service, including prior authorization, as applicable, before proceeding with the request for the device or modification through the waiver.

2. Ensure the individual has followed the appeal process.

3. Upon receipt of the denial, the CMA must make provider contact within five calendar days to schedule a physical or occupational therapy evaluation for the individual in order to determine the medical necessity required for obtaining a device or modification through waiver funding.

- Upon completion of a physical or occupational therapy evaluation, the CMA must seek a minimum of three vendor or contractor bids for the device or modification. It must ensure that a vehicle modification vendor is selected, and due diligence taken to schedule work to

start within 45 days of the request. The CMA must keep the individual updated on the status of his or her request throughout the procurement process.

The CMA will verify an individual's Medicaid eligibility in MITS prior to approving a vehicle modification or supplemental adaptive assistive device bid. The CMA will approve the lowest cost alternative that meets the individual's needs as determined during the assessment process. Once the service is approved, the CMA must update the Person-Centered Services Plan to reflect the approved service.

**Implementation Expectations**

1. Send service requests, with a response deadline specified, to all providers within the individual's county and all contiguous counties The request is to identify providers who are interested in bidding based on the individual's service need identified through the therapy evaluation.

2. The individual will then identify the providers who have permission to develop the bid.

3. The CMA will outreach the identified interested providers, who must submit a bid to the CMA that includes all elements required in 5160-46-04.

4. The CMA must verify the individual's Ohio Home Care Waiver eligibility in Ohio Benefits and MITS prior to awarding and authorizing the service to the selected provider.

5. The CMA must authorize the service to the provider who can complete the service as required and as the lowest-cost alternative that meets the individual's assessed needs.

6. The CMA must contact or visit the individual within 10 calendar days to verify satisfaction with the device or modification.

7. The CMA must authorize the cost of services on the Person-Centered Services Plan within 72 hours of verifying individual's satisfaction.

# Appendix B

# Home Modifications

Effective January 1, 2019 and pursuant to the newly aligned service specifications and provider requirements set forth in Rule 5160-44-13 of the Administrative Code, ***"Home Modifications"*** are defined as environmental adaptations to the private residence(s) of an individual required by the individual's person-centered services plan, that are necessary to ensure the health, welfare and safety of the individual or that enable the individual to function with greater independence in the home.

Adaptations include, but are not limited to, the installation of ramps and grab bars, widening of doorways, modification of bathroom or kitchen facilities, or the installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Home modifications also include replacement of previous modifications when it is determined they cannot be repaired through another resource.
Home modifications may be authorized up to 180 days pre-enrollment for individuals transitioning from a facility to the community. The CMA must conduct an assessment of the proposed post-discharge residence to determine if a Home Modification need is present.

The process for requesting a home modification is set forth in OAC 5160-44-13, and the cost cannot exceed $10,000 in a calendar year per individual. The Ohio Department of Medicaid (ODM) or its designee is required to approve the lowest cost alternative that meets the individual's assessed needs. The date of service for home modifications approved post-waiver enrollment is the date of job completion. The date of service for home modifications approved and provided pre-waiver enrollment shall be the date on which the individual leaves the institutional setting.

Home modifications do not include:

• Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual including, but not limited to, carpeting, roof repair and central air conditioning.

• Adaptations that add to the total square footage of the home, except when necessary to complete the adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- New, replacement home modifications or repair of previously approved home modifications that have been damaged because of apparent misuse, abuse or negligence.

**Policy Guidance Regarding Customization of New Builds**

Home modifications are not intended to cover the general construction, materials and labor associated with the building of a new home (i.e., putting up walls, electrical work, and plumbing, etc.). However, there may be some instances in which it is more prudent and cost effective to permit the use of the service to cover expenses related to the installation of ramps and grab bars, customization of doorways to accommodate wheelchairs, customization of bathroom or kitchen facilities (e.g., walk-in baths, roll-in showers, lowered counters), or the installation of specialized electric and plumbing systems and certain kinds of equipment otherwise acceptable under the service. In such instances, labor and materials above and beyond that required for a typical build may be covered. Funds will not be used to pay for items/ materials that are of general utility or are intended to enhance a home’s appearance.
Authorization of home modifications as part of a new build shall be based on the individual’s assessed need as determined by the case management agency. It is recommended that an evaluation by an appropriately qualified professional be conducted to determine the suitability of

the immediate environment where the home modification will occur. This could include a review of blueprints.

The fixed cost proposal for a home modification involving a new build must include all the following:
• The items required in OAC 5160-44-13-
• An original price list of items needed for a typical build, including labor costs; and
• A second price list for the recommended adaptations, including labor costs.

The home modification service will fund the lowest cost alternative that meets the individual's assessed needs, or the difference between typical building costs and the modification costs, whichever is less. The date of service is the new home's closing date, and that date will drive the calendar year from which to credit home modification funds.

# Appendix C

# Home Maintenance and Chore Services

Home maintenance and chore is a service that maintains a clean and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability.

- Services shall not exceed a total of $10,000 in a calendar year per individual.
- They may be authorized up to 180 consecutive days prior to an individual's transition from an institutional setting into the community.
- The date of service for home maintenance and chore services approved and provided pre-waiver enrollment shall be the date on which the individual leaves the institutional setting.
- Covered home maintenance and chore services include:
    - minor home maintenance and repair,
    - heavy household cleaning,
    - non-routine disposal of garbage and yard maintenance posing a threat to the individual's health, safety, and welfare, and
    - pest control and related tasks to prevent, suppress, eradicate, or remove pests posing a threat to the individual's health, safety, and welfare.

- The CMA must conduct an assessment of the proposed post-discharge residence to determine if a home maintenance and chore need is present. The CMAs will facilitate the service activity prior to enrollment.
    - The CMA must conduct the initial assessment for an individual in a facility. The CMA, along with the individual and/or Authorized representative will identify the home maintenance and chore service need that must be completed prior to OHCW enrollment.

- The CMA must conduct an assessment at the individual's intended residence to evaluate the need for the requested or identified home maintenance and chore service.

- The Ohio Department of Medicaid (ODM) or its designee is required to approve the lowest cost alternative that meets the individual's assessed needs. The date of service for home maintenance and chore approved post-waiver enrollment is the date of job completion. The date of service for home maintenance and chore approved and provided pre-waiver enrollment shall be the date on which the individual leaves the institutional setting.
- For individuals transitioning to the community and received home maintenance and chore service and were **not** enrolled in OHCW, the CMA must notify ODM at BCO@medicaid.ohio.gov
    - The email must include the individual's name, MMIS number, DOB, provider name, and cost of approved service(s).
    - All communications must be documented in the individual's electronic case file and any documents related to the service will be uploaded.

# Appendix D

# Community Transition Services

Community Transition Services (CTS) was added to the menu of Home Care Waiver service options effective July 1, 2019. The service is designed to provide individuals access to specific goods and services that support a safe transition into the community from an institutional setting, and the service is available 180 days prior to the individual's transition into the community.

The CMA will conduct the initial assessment for an individual in a facility. If the individual has been identified as a Home Choice candidate, the assessor will email the assessment outcome to the Home Choice mailbox: home_choice@medicaid.ohio.gov.

The Home Choice program will link the designated Transition Coordination (TC) entity to the individual who requires CTS. The TC will meet with the individual and determine what goods and services are necessary to support transition to the community. The goods, services and estimated costs will be documented on the ODM-approved CTS Template by the TC and sent to the CMA's designated email box for review/approval/denial/CMA comments. The CMA will have three business days from the date the email request was sent to provide a response to the TC via the CTS template. This process will be replicated as often as necessary to ensure all goods and services (within the $2000 cap) required for safe transition are addressed. The CMA will document all interactions into the ODM-approved case management system, including uploading copies of all CTS templates exchanged. The TC will spend according to the approved plan and retain receipts for all CTS purchases made.

The TC will remain available to the individual for a period of 30 days post-discharge. At the time of discharge, the CMA is responsible to initiate the appropriate waiver services and verify the usage of CTS with the individual. At the end of the 30-day community period with the TC, a

final accounting of the CTS utilization will be submitted to the CMA, including copies of receipts, for the CMA to review. The CMA will have three business days from receipt to respond to the TC with confirmation the PCSP has been updated, or with feedback on edits required and request for resubmission.

For individuals transitioning to the community and who are **not** enrolled in Home Choice, the CMA may work with an ODM-approved CTS provider. The CMA will post referrals for non-Home Choice CTS on the provider portal in the ODM-approved case management system. The CTS Template is not required for non-Home Choice CTS coordination, as the ODM-approved case management system may be utilized for communication with potential providers related to service bids and proposals. The CMA will enter authorization information into the ODM-approved case management system while the individual is in an “Applicant” status. Authorization information will include the estimated cost of service(s) and the provider’s administrative fee (non-Home Choice CTS may include an administrative fee), which have been approved by the CMA. All communications will be documented in the individual’s electronic case file and any documents related to the service will be uploaded. The CMA will have three business days from receipt of invoice and accompanying receipts to approve/deny the final service cost submitted by the CTS provider. The CTS provider will be responsible for costs incurred that are not approved by the CMA or that exceed the $2,000 per waiver enrollment service cap.

# Appendix E

# MCP Communication Protocol

**Communication Protocol**
**Updated 2/22/19**

This communication protocol is designed to assist the Ohio Home Care/Passport/Assisted Living waiver case management agencies and Medicaid managed care plan (MCP) staff that provide services to adult extension Medicaid consumers (sometimes also referred to as Medicaid expansion or group 8) enrolled in a MCP and receiving waiver services.

**MCP staff**

- Initial identification – The 834 files identify waiver members, their respective waiver (i.e., Ohio Home Care, Passport or Assisted Living) and the attached lists provide point of contact information for each waiver care management entity. Until the process is automated, MCPs need to contact the applicable waiver care management agency to request a copy of the most recent assessment and service plan. Once received, this information should identify the case manager/waiver service coordinator for on-going communication. If the MCP needs to contact the case manager/waiver service coordinator before the assessment and service plan information is received, MCPs can request this information at the time of the initial contact. Please be mindful of efficiencies with this process and try to limit the contact to request the assessment/service plans to monthly (i.e., identify all new members enrolled that month that reflect waiver eligibility/all current members that were approved that month for waiver services and ask for all at onecall).
- Provision of services – Anytime a MCP makes a prior authorization decision for home health aide/nurse or durable medical equipment, in addition to notifying the member and the requesting provider of the decision, the MCP must also promptly notify the case manager/waiver service coordinator of the decision. If the plan's decision was to deny the prior authorization request, the member notification will include information on appeal rights.
- Incidents – For members receiving Ohio Home Care Waiver services, MCPs must promptly report any incident that meets the definition in OAC rule 5160-45-05(F) to the case managers. For members receiving Passport or Assisted Living Waiver services, MCPs must promptly report incidents as defined in the Ohio Department of Aging (ODA) rule OAC 173-39-01 to the ODA Waiver case managers. MCP staff must also continue to report as bound by federal, state or local law or professional licensure or certification asrequired.

**Waiver care management agency staff**

- Identification of MCP care manager/single point of contact – Waiver care management

agency staff can use the attached list to contact the MCPs.

- MCP questions/assistance – With the exception of emergency services, services provided by Ohio Department of Mental Health and Addiction Services certified providers, federally qualified health centers, and qualified family planning providers (Title X); state plan services for MCP adult extension members must be received from MCP panel providers or providers authorized by the MCP. Additionally, MCPs can have different prior authorization requirements than Medicaid fee-for- service. Therefore, case managers/waiver service coordinators should contact the MCP for assistance when a need for state plan services is identified. If prior authorization is not required, the MCP can assist with identifying an available panel provider as well as answer any process questions. If prior authorization is required the MCP will work with the member and their panel provider to make a prior authorization decision and initiate any approved services.

### MCP and Waiver Care Management Agency Staff

- Collaboration – In addition to the above, communication between staff is encouraged, especially regarding pertinent issues. For example, staff will need to communicate a change in MCP care manager/Ohio Home Care case manager/Passport or Assisted living waiver service coordinator as well as any significant change event. Other opportunities for collaboration include connecting to discuss identified needs, the provision of services, a change in behavior or health status, hospitalization, etc. Staff must ensure that any emails, faxes, file transfers etc. are sent via a secure process.
- Messaging on multiple care managers – Staff will need to be clear on their role of interacting with the individual and why they have more than one manager/coordinator working with them. However, whether the individual contacts the MCP care manager, Ohio Home Care case manager or Passport/Assisted Living waiver service coordinator for assistance, that entity should assist with the issue, which may include a warm hand-off if applicable.

## Ohio Home Care Waiver Contacts

This contact list is for the managed care plans (MCPs) to use to contact the waiver care management agency for adult extension MCP members receiving Ohio Home Care waiver services. MCPs will first need to call **614-466-6742** to determine which case management agency to contact and then based on the member's county of residence contact the applicable individual listed below to request a copy of the assessment/service plan/case manager information. For urgent situations, each case management agency has an after-hour live answer. The toll-free numbers listed will go to that number after-hours.

| CLEVELAND | |
|---|---|
| CareSource 1-877-209-3154<br>Esther Davis<br>Esther.Davis@caresource.com | CareStar- 1-800-616-3718<br>Gloria White<br>cmasstCleveland@carestar.com |

| 216-280-7244<br><br>Natalie Hetzel, Clinical Manager<br>Natalie.Hetzel@Caresource.com<br>216-645-1853 | | 614-472-8848<br>Valerie Hawkins<br>vhawkins@carestar.com<br>614-729-6326 | |
|---|---|---|---|
| **Counties** | | | |
| Ashtabula | Columbiana | Cuyahoga | Geauga |
| Lake | Lorain | Mahoning | Medina |
| Portage | Stark | Summit | Trumbull |
| Wayne | | | |

| **COLUMBUS** | | | |
|---|---|---|---|
| CareSource 1-844-832-0159<br>Angelina Triplett<br>Angelina.Triplett@caresource.com<br>216-212-4481<br>Natalie Hetzel, Clinical Manager<br>Natalie.Hetzel@Caresource.com<br>216-645-1853 | | CareStar 1-800-616-3718<br>Patricia Weiser<br>cmasstColumbus@carestar.com<br>614-729-1591 ext 4876<br>Valerie Hawkins<br>vhawkins@carestar.com<br>614-729-6326 | |
| **Counties** | | | |
| Ashland | Crawford | Defiance | Delaware |
| Erie | Fairfield | Fayette | Franklin |
| Fulton | Henry | Huron | Knox |
| Licking | Lucas | Madison | Marion |
| Morrow | Ottawa | Paulding | Pickaway |
| Richland | Sandusky | Seneca | Union |
| Williams | Wood | Wyandot | |

| **CINCINNATI** | | | |
|---|---|---|---|
| CareSource 1-855-717-5676<br><br>Natalie Hetzel, Clinical Manager<br>Natalie.Hetzel@Caresource.com<br>216-645-1853 | | CareStar 1-800-616-3718<br>Valerie Hawkins<br>cmasstCincinnati@carestar.com<br>614-729-6326<br>Tyler Woolnough<br>twoolnough@carestar.com<br>513-666-3623 | |
| **Counties** | | | |
| Allen | Auglaize | Butler | Champaign |
| Clark | Clermont | Clinton | Darke |
| Greene | Hamilton | Hancock | Hardin |
| Logan | Mercer | Miami | Montgomery |

| | | | |
|---|---|---|---|
| Preble | Putnam | Shelby | Van Wert |
| Warren | | | |

| MARIETTA | |
|---|---|
| CareSource 1-855-288-0003<br>Karla Leach<br>Karla.Leach@caresource.com<br>216-556-3917<br><br>Natalie Hetzel, Clinical Manager<br>Natalie.Hetzel@Caresource.com<br>216-645-1853 | CareStar 1-800-616-3718<br>Patricia Weiser<br>cmasstColumbus@carestar.com<br>614-729-1591 ext 4876<br>Valerie Hawkins<br>vhawkins@carestar.com<br>614-729-6326 |

| Counties | | | | |
|---|---|---|---|---|
| Adams | Athens | Belmont | Brown | Carroll |
| Coshocton | Gallia | Guernsey | Harrison | Highland |
| Hocking | Holmes | Jackson | Jefferson | Lawrence |
| Meigs | Monroe | Morgan | Muskingum | Noble |
| Perry | Pike | Ross | Scioto | Tuscarawas |
| Vinton | Washington | | | |

## Passport and Assisted Living Waiver Contacts

This contact list is for the managed care plans (MCPs) to use to contact the waiver care management agency for adult extension MCP members receiving Passport or Assisted Living waiver services. MCPs will first need to call Gayle Lee at 614-466-5500 and then based on Gayle's direction contact the applicable individual listed below to request a copy of the assessment/service plan/waiver service coordinator information. For after hours, messages can be left for a return call.

| AA* | Name | Title | Telephone Number | Email Address |
|---|---|---|---|---|
| 1 | Bronwyn Julian | Manager PASSPORT/AL | 513-824-3417 | bjulian@help4seniors.org |
| 2 | Meaghan Johnson | Waiver Services Manager | 937-341-3092 | mjohnson@info4seniors.org or MyCare_ProviderReporting@info4seniors.org |
| 3 | Jennifer Gilkey<br>Ashley Lehmkuhle | | 419-222-7723 | Group8Contact@psa3.org |
| 4 | Jayne Wagner | Clinical Manager | 419-725-6933 | jwagner@areaofficeonaging.com |

| | | | | |
|---|---|---|---|---|
| 5 | Beth Fryman | LTC Manager | 419-522-5612 x1108 | bfryman@aaa5ohio.org |
| 6 | Margaret Centofanti | Screening Department | 800-589-7277 | mcentofanti@coaaa.org |
| 7 | Connie Montgomery<br>Debbie Gulley | | 800-582-7277 | cmontgomery@aaa7.org<br>dgulley@aaa7.org |
| 8 | Dawn Weber | Home Care Director | 800-331-2644 x2360 | Dweber@buckeyehills.org |
| 9 | Michele Bates<br>Val Sampson | Consumer Care Division Director<br>ADRN Director | 740-435-4706<br>740-435-4932 | mbates@aaa9.org<br>vsampson@aaa9.org |
| 10a | Luci Peto | CSSD Medicaid Liaison | 216-621-0303 ext. 1269 | lpeto@psa10a.org |
| 10b | Susan Sigmon | VP, LTSS | 330-899-5206 | ssigmon@dhad.org |
| 11 | Lorie Eichelberger<br>Jami Gilronan | Assessment<br>PASSPORT/ALW | 330-505-2300, ext 173<br>330-505-2322 | l.eichelberger@aaa11.org<br>j.gilronan@aaa11.org |
| CSS | Shirley Berning | Clinical Manager | 1-800-521-6419 ext 1102 | sberning@cssmv-sidney.org |

*see following list of counties associated with each PAA

## Passport and Assisted Living Waiver Contact – Page 2

1 – Butler, Clermont, Clinton, Hamilton and Warren

2 - Clark, Greene and Montgomery

3 – Allen, Auglaize, Hancock, Hardin, Mercer, Putnam, and Van Wert

4 - Defiance, Fulton, Erie, Henry, Lucas, Ottawa, Paulding, Sandusky, Williams, and Wood

5 - Ashland, Crawford, Huron, Knox, Marion, Morrow, Richland, Seneca, and Wyandot

6 – Delaware, Fairfield, Fayette, Franklin, Licking, Madison, Pickaway and Union

7 – Adams, Brown, Gallia, Highland, Jackson, Lawrence, Pike, Ross, Scioto and Vinton

8 - Athens, Hocking, Meigs, Morgan, Monroe, Noble, Perry and Washington

9 - Belmont, Carroll, Coshocton, Guernsey, Harrison, Holmes, Jefferson, Muskingum, and Tuscarawas

10a – Cuyahoga, Geauga, Lake, Lorain and Medina

10b- Portage, Stark, Summit, and Wayne

11 – Ashtabula, Columbiana, Mahoning and Trumbull

CSS – Champaign, Darke, Logan, Miami, Preble and Shelby

## Medicaid Managed Care Plan (MCP) Contacts

This contact list is for the waiver case management agencies to use to contact the Medicaid MCPs to facilitate collaboration, coordination and communication for MCP adult extension members who are receiving Ohio Home Care, Passport or Assisted Living Facility Waiver services.

| Managed Care Plan | Point of Contact | 24-Hour Nurse Advice Line | Care Management Line |
|---|---|---|---|
| Buckeye Health Plan | Karen Brophy<br>866-246-4356 ext 24313<br>kbrophy@centene.com<br>OR<br>Laura Paynter<br>866-246-4356 ext 24446 or<br>216-319-0481<br>lpaynter@centene.com | 866-246-4358 | 866-549-8289 |
| CareSource | Natalie Moon-Storer<br>937-591-1754<br>Natalie.Moon-Storer@caresource.com<br>OR<br>Julieanne Jenkins<br>740-395-1258<br>Julieanne.Jenkins@caresource.com | 866-206-0554 | 866-206-0610 |
| Molina Healthcare of Ohio | Deidre Palmer<br>800-642-4168 ext 216341 or<br>614-212-6341<br>Deidre.palmer@molinahealthcare.com | 888-275-8750 | 888-275-8750 |
| Paramount Advantage | Mary Crigger<br>419-887-2210<br>mary.crigger@promedica.org<br>OR<br>Christine Haydock<br>419-887-2239<br>Christine.Haydock@ProMedica.org | 800-234-8773 | 800-891-2520 |
| UnitedHealthcare Community Plan | Sarah M. Froehling<br>952-406-4877<br>sarah.froehling@uhc.com<br>OR<br>Diane McCutcheon<br>614-410-7352<br>Diane.mccutcheon@uhc.com | 800-542-8630 | 800-895-2017 |

# Appendix F

# Ohio Map Regions

# Appendix G

Family Members as Providers
ODM-administered Waivers

| Family Member = NURSE | | | Family Member = AIDE | | |
|---|---|---|---|---|---|
| The NURSE is the Individual's | Agency Employee | Non-Agency | The AIDE is the Individual's | Agency Employee | Non-Agency |
| Adoptive Parent of Adult Individual | YES* | YES* | Adoptive Parent of Adult Individual | YES* | YES* |
| Adoptive Parent of Minor Individual | YES* | NO | Adoptive Parent of Minor Individual | NO | NO |
| Aunt, Uncle, Niece, Nephew | YES* | YES* | Aunt, Uncle, Niece, Nephew | YES* | YES* |
| Birth Parent of Adult Individual | YES* | YES* | Birth Parent of Adult Individual | YES* | YES* |
| Birth Parent of Minor Individual | YES* | NO | Birth Parent of Minor Individual | NO | NO |
| Child of Individual - Adoptive, Birth, Step | YES* | YES* | Child of Individual - Adoptive, Birth, Step | YES* | YES* |
| Cousin | YES* | YES* | Cousin | YES* | YES* |
| Foster Parent of Individual | NO | NO | Foster Parent of Individual | NO | NO |
| Foster Sibling | YES* | YES* | Foster Sibling | YES* | YES* |
| Grandchild of Individual | YES* | YES* | Grandchild of Individual | YES* | YES* |
| Grandparent of Individual | YES* | YES* | Grandparent of Individual | YES* | YES* |
| In-laws: Mother, Father, Sister, Brother, Daughter, Son | YES* | YES* | In-laws: Mother, Father, Sister, Brother, Daughter, Son | YES* | YES* |
| Siblings: Birth, Adoptive, Step, Half | YES* | YES* | Siblings: Birth, Adoptive, Step, Half | YES* | YES* |
| Significant Other (not spouse) | YES* | YES* | Significant Other (not spouse) | YES* | YES* |
| Spouse | YES* | NO | Spouse | NO | NO |
| Spouse of Grandchild of Individual | YES* | YES* | Spouse of Grandchild of Individual | YES* | YES* |
| Spouse of Grandparent of Individual | YES* | YES* | Spouse of Grandparent of Individual | YES* | YES* |
| Step-Parent of Adult Individual | YES* | YES* | Step-Parent of Adult Individual | YES* | YES* |
| Step-Parent of Minor Child Individual | YES* | YES* | Step-Parent of Minor Child Individual | YES* | YES* |

The contents of this chart are based upon OAC Rules 5160-45-01 (EE), 5160-44-22(D), 5160-44-27(G) and 5160-46-04(A) .

*Please note a relationship of POA, legal or court appointed guardian existing between provider and individual may also render the provider ineligible to provide services unless one of the exceptions applies under OAC Rule 5160-44-31(F) or 5160-45-10 (F).

Effective 1/1/19

# Appendix H

| FAMILY MEMBERS AS ODM-ADMINISTERED WAIVER SERVICE PROVIDERS | |
|---|---|
| **Definition of Family Member** | *"Legally Responsible Family Member,"* as that term is defined in **OAC Rule 5160-45-01 (EE)** and used in the Ohio Home Care Waiver **(OAC Chapters 5160-44, 5160-45 and 5160-46)**, is the individual's spouse, or in the case of a minor, the individual's birth or adoptive parent, or foster caregiver. |
| **Eligible Waiver Nursing Providers** | Pursuant to **OAC Rule 5160-44-22 (D)(4)**, waiver nursing services cannot be performed by the individual's legally responsible family member as that term is defined in **OAC Rule 5160-45-01** unless the legally responsible family member is employed by a Medicare-certified home health agency or otherwise-accredited agency and the individual is enrolled on an ODM-administered waiver.<br><br>Pursuant to **OAC Rule 5160-44-22 (D)(5),** waiver services cannot be performed by the individual's legally responsible family member, as that term is defined in **OAC rule 173-39-02** when the individual is enrolled on an ODA-administered waiver.<br><br>**OAC Rule 5160-44-22 (D)(6)** prohibits a foster parent from providing waiver nursing services. |
| **Eligible Waiver Personal Care Aide Providers** | Pursuant to **OAC Rule 5160-46-04 (A)(5)(f)**, personal care aide services cannot be performed by the individual's legally responsible family member.<br><br>**OAC Rule 5160-46-04 (A)(5)(g)** prohibits a foster parent from providing personal care aide services. |
| **Eligible Home Care Attendant Service Providers** | Pursuant to **OAC Rule 5160-44-27(G)(6),** home care attendant services cannot be performed by the individual's legally responsible family member.<br><br>Pursuant to **OAC Rule 5160-44-27(G)(7),** home care attendant services cannot be performed by the individual's legal guardian or foster caregiver. |
| **ODM-administered Waiver Provider Conditions of Participation** | Pursuant to **OAC Rule 5160-45-10 (F) and OAC Rule 5160-44-31(F)**, ODM-administered waiver service providers shall not be designated to serve or make decisions for the individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative, or as a representative payee as that term is described in paragraph (F)(3) of these rules, except as provided in paragraphs (F)(1) to (F)(4) of these rules.<br><br>(1) A provider may be appointed by the court to serve as legal guardian for the individual pursuant to Chapter 2111. of the Revised Code if the provider is a family member.<br><br>(2) A provider may serve as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship if the provider is the individual's parent or spouse.<br><br>(3) A provider may serve as the individual's representative payee if the provider is the individual's parent or spouse. For purposes of this rule, "representative payee" means a parent or spouse the individual designates to receive and manage payments that would otherwise be made directly to the individual.<br><br>(4) A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship for the individual if:<br><br>(a) The provider was serving in that capacity prior to September 1, 2005; and<br><br>(b) The provider was the individual's paid medical provider prior to September 1, 2005; and<br><br>(c) The designation is not otherwise prohibited by law. |

# Appendix I
## Self-Direction

This Appendix is a placeholder and will be updated as Self-Direction is developed and implemented in the Home Care Waiver.