Case Management Guide

Ohio Home Care Waiver

Effective July 1, 2018

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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. Additionally, they shall participate in a Person-Centered Services Planning process that is consistent with the requirements of 42 CFR 441.301.

The Ohio Department of Medicaid (ODM) -administered Ohio Home Care Waiver is governed by rules primarily set forth in Chapters 5160-45 and 5160-46 of the Ohio Administrative Code. 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 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 in order to clarify expectations, improve performance and to better meet the needs of individuals serviced 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 may 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 recruits providers, monitors health and welfare, and conducts provider oversight and incident investigations. 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 Centers for Medicare and Medicaid Services (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 will be 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.

Subsequent to application for waiver enrollment, at any time 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 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 between the ages of 21 and 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.

The applicant or authorized representative must agree to participate in the ODM-administered waiver program 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 and agree to its implementation by signing and dating the plan.

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. 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 and assigned to the CMA. Per its contract with ODM, each CMA is required to complete the ODM-approved assessment within **30** calendar days. If it is designated a priority assessment, then it must be completed within **10** calendar days of the assignment. The individual can include other parties of their choosing in the assessment. Criteria for priority assessments is outlined in section C-4 of this guide and within OAC rule 5160-46-02.

The Case Management Agency must contact the individual to schedule the annual assessment at least 30 calendar days prior to the date the next assessment is due. The CMA must also 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 an eligibility determination made no more than 365 calendar days after the previous eligibility determination.

During initial evaluation and reevaluation, an RN, LSW or LISW uses the ODM-approved 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 an Ohio Department of Medicaid form 02361 "HOME Choice Application." Information about the HOME Choice program can be found at http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx .

The CMA must create the Long Term Care detail screen in Ohio Benefits within three business days of the completion of the OHC Waiver Program eligibility determination.

In the event no long term care program block is visible in the Ohio Benefits (OB), the CMA must notify the ODM Intake Coordinator.

Ohio Home Care Waiver Program enrollment is contingent on the individual being eligible for the Long Term Care program block of Ohio Medicaid as verified with eligibility in Ohio Benefits and an open Ohio Home Care Waiver span in MITS. The Case Management Agency should not activate an individual's OHC Waiver enrollment in the ODM-approved Case Management System until they verify there is OHC Waiver eligibility in Ohio Benefits and MITS.

The CMA must maintain documentation of each assessment and evidence gathered to make the determination. 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 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 his or her level of care. It assesses the individual's ability to live independently, as well as his or her ability to direct his or her 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 their informal caregivers and/or authorized representative. Assessments will also include information from the individual's current professional support team (physician, specialists, providers, etc.) and any other sources identified by the individual as having information that will be useful in determining his or her level of care, as well as his or her 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 that 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 that 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
- An acute medical condition that results in institutionalization
- Change or deterioration in the individual's condition, including election of hospice benefits
- Change of residence
- Three reported incidents in 90 days
- Receipt of a new mobility device
- 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 event occurred, the CMA must complete a visit and an event based update, using the ODM-approved tool, by the end of the third full calendar day following the CMA's determination. For individuals who are in facilities located outside of the state of Ohio, or for individuals who are unable to be accessed in the treating facility, 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. A face-to-face visit and event based update assessment by the Case Manager, within three calendar days of learning the individual has been discharged from the facility, is required following identification of a significant change. The completion of a full, comprehensive, event based assessment will change the annual reassessment date. Partial updates to the 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. At that time they 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.

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.

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

Customer Service

- Listening to the individual and addressing all problems 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 an 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. For all service additions and changes, the Case Manager must contact the individual within 24 hours 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.

6. 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.

7. 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.

8. 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 identification, 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.

9. The Case Manager must monitor the quality of the 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.

10. 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.

11. 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 later in section F-10 and F-11 of 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' because they are eligible for Medicaid through Section (a0910)(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.

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
- Emergency Response System
- Home Care Attendant
- Home Delivered Meals
- Home Modifications

- Out-of-Home Respite Care
- Personal Care Aide
- Supplemental Adaptive and Assistive Devices
- Supplemental Transportation
- Waiver Nursing

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

Adult Day Health 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.

Emergency Response Services: An Emergency Response System is available to individuals who can be left unattended for periods of time but who may need, and are able, to summon emergency assistance, if needed. The service utilizes telecommunications equipment, an emergency response center, and a medium for two-way, hands-free communication between the individual and the emergency response center. Personnel at the emergency response center intervene when the center receives an alarm signal from the equipment.

Home Care Attendant: Home Care Attendant services are waiver services available to individuals who meet the specific requirements of Ohio Administrative Code Rule 5160-46-04.1 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 or 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.

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 not be used at the same time as, or when a Home Care Attendant, Personal Care Aide, or Nurse is in the home and can prepare a meal for the individual.

Home Modifications: Home modifications can be approved only after an occupational therapist or physical therapist determines that the individual requires an adaptation to the immediate home environment in order to increase the individual's independence or ability to access his or her home. The owner of the home to be modified must provide written consent within 30 days of request to the CMA prior to approval of any modifications. The CMA must assist the individual to coordinate the job specifications and will submit a request-for-bid as directed in Ohio Administrative Code Rule 5160-46-04 (E). The CMA will award the service agreement to the lowest cost alternative. Other relevant factors will be considered as well. 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 Appendix A of this guide.

Out-of-Home Respite Services: Out-of-home respite services 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.

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.

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, 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. 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 Ohio Administrative Code 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.

Waiver Nursing: 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.

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 the aforementioned 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: 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 services as identified in the Person-Centered Services Plan. The Person-Centered Services Plan reflects all authorized services, including the cost of 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, an increase in services is needed 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 and Adaptive/Assistive Devices).

• Person-Centered Services Plans that include more than 112 paid hours per week of personal care aide services, nursing or 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. The CMAs submit reports of all emergency authorizations to ODM quarterly, of which ODM reviews a random sample.

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-3: State Plan Nursing Services

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

Nursing Consultation - An RN consultation service shall be performed by the CMA 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 5160-46-04 of the Administrative Code for waiver nursing services.

E-4: Healthchek

Ohio Administrative Code 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. In the event 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 the individual would be eligible for the increased service.

In the event 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 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-5: Post-Hospital Benefits

Post-hospital benefits are available to all Medicaid state-plan recipients for no more than 60 days after discharge. To be eligible, the 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-6: 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-7: HOME Choice Program

HOME Choice is a transition program that assists persons of any age with any type of disability to move from a long-term care facility (e.g. a nursing facility, hospital, or residential treatment 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 a qualified residence upon discharge
- Not previously enrolled and disenrolled from the HOME Choice program

Individuals accepted to work with the HOME Choice program collaborate with the HOME Choice transitional staff (Pre-Transition Case Manager and Transition Coordinator) 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, Pre-Transition case manager, 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 transitional staff 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 services, the HOME Choice program provides "wrap-around" services and supports for a limited time while the person is in the community. For example, the Transition Coordinator, follows the individual for the first 90-days to enhance sustainability and community integration.

The role of the CMA is to initiate or resume the appropriate waiver services for the individual at the time of discharge. The CMA is also responsible for integrating HOME Choice services into the Person-Centered Service Plan during the time the individual is enrolled in HOME Choice. During this time, the CMA also functions as the HOME Choice case manager and reports any significant changes in the status of the individual to HOME Choice Operations.

HOME Choice is part of the Federal Grant Program known as Money Follows the Person. The program will continue to enroll individuals as long as the grant permits. The current cutoff date for new enrollees is December 31, 2018.

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 (e.g., a legal guardian).

The person-centered planning process:

- Includes a team of people chosen by the individual.
- Provides necessary information and support to ensure that 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 are 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 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 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 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 that 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 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 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 entity responsible for Person-Centered Services Planning and ongoing case management. ODM monitors and oversees the CMA's 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. The CMA also explores additional informal/formal supports that can be added, and referrals and linkages 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 service provider options available (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).

On an ongoing basis, it is the CMA's responsibility to monitor the individual's Person-Centered Services Plan 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 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, when needed.
- 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 that the Person-Centered Services Plan is understandable to the individual, and 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 are limited English proficient. 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 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 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 that 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 that 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: 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: 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 rule 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 rule 5160-45-10 also requires that 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-5: 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. This 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-6: Services in Schools or Other Day Programs

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.

F-7: 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 are:

- 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. The back-up plan using Nursing is considered anticipated services to replace Home Care Attendant services.

F-7: 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 that it is uploaded into the clinical record. The Case Manager should also ensure that 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 that 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 that the 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-9: 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 that individuals can exercise free choice of provider;

- To monitor and ensure the appropriateness of service delivery and the outcomes identified on the person-centered service plan;
- To monitor and ensure that services meet the needs of the individual;
- To monitor and ensure that back-up plans are effective;
- To ensure that 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-10: 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 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, which include, without limitation, 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 an Acknowledgement of Responsibility Agreement 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-11: Contact Schedules

At six months' enrollment, the Case Manager must meet with the newly enrolled individual to ensure that services are meeting his or her needs, update the Person-Centered Services Plan, and ensure that 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, 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 and supplemental adaptive and assistive device 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, must produce, and provide copies of an appeal summary to the hearing officer and to the individual on a 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 that 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 that 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 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 Rule 5101:6-7-03 of the Ohio Administrative Code, 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 have been unresponsive to their requests, or have 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, and 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 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 ongoing, 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 an "Acknowledgement of Responsibility" form, or explore development of a behavior support plan by appropriate personnel.

H-2: Acknowledgement of Responsibility

When the individual poses or continues to pose a risk to his or her health and welfare, the CMA must develop and implement an Acknowledgment of Responsibility (AR). The AR is 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): How to Develop an Acknowledgement of Responsibility Agreement (AR):

• Identify the potential risk to the individual's health and welfare and what behaviors or concerns are putting the individual at risk.
• Identify the goal – what needs to change in order to reduce risk(s) to the health and safety of the individual?
• Develop objectives that are specific, measurable, realistic and timely to reduce the identified behavior or concern that is impacting health and safety.

• Develop action steps (interventions) with the individual's input, and in collaboration with the Case Manager, to implement in order to mitigate against the risks.

The individual and/or the legal guardian, as applicable, must sign the AR. If she or he does not, the CMA must document the refusal to sign.

The AR must be identified in the Person-Centered Services Plan. The AR 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.

The AR 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 that 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 AR 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 show a progression of how the individual failed to adhere to the AR and actions the case manager has taken to support the individual in following the AR. The AR must be attached to the recommendation at the time of the request. Any incidents and communication notes documenting the individual's nonadherence must also be addressed in the AR. If a concern

expressed in the recommendation is not addressed in the AR, it will be returned to the CMA and asked that it be added and monitored for at least one month. The request must also include documentation reflecting interdisciplinary team collaboration has occurred to review the identified safety concern(s), discuss interventions, progress or lack thereof, and determine whether all relevant interventions have been attempted and deemed unsuccessful. Finally, the submission must include a transition plan for ODM review and a statement indicating the recommendation for disenrollment has been reviewed and approved by the CMA's Clinical Director. Requests received by ODM will undergo review by the interdisciplinary clinical team and a written response will be issued to the CMA. ODM responses may include request for additional follow up action(s) or a recommendation to proceed with notice of disenrollment due to 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 vehicles

• 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.

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 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.

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 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.

In the event of a death of an individual, the CMA must notify and provide relevant details to the local county coroner when the CMA is aware that the:

- Individual's death was a result of an accident, injury, or trauma.
- Individual's death was potentially accidental, suicidal or homicidal.
- Individual has a history of drug or alcohol abuse and/or misuse of medications including controlled substances.
- Individual has been a victim, or has a history, of alleged abuse, neglect, or exploitation.

• Individual's death is questionable, potentially suspicious, and/or under unknown circumstances.

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 Provider Oversight Contractor:

- The CMA must report incidents in ODM-approved assessment and case management system within 24 hours of the CMA discovery.

  Incidents Alerts: Incident alerts are described in OAC 5160-45-05 and must be reported within 24 hours of discovery to both the Provider Oversight Contractor ***and*** ODM due to the severity and/or impact of the incident on the individual or the need for ODM involvement. ODM monitors each incident alert to ensure that the investigation, remediation, and prevention planning are timely and effective.

  Notification must include the following information in the subject line: INCIDENT ALERT, alert type, incident number assigned by the incident database. ODM reviews all pertinent information, including investigation outcomes, recommendations, final reports, approved prevention plans and verification of implementation of the approved prevention plans. ODM does not close the incident alert until after the health and safety of the individual has been ensured.

- 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 investigation concludes, the CMA must create a prevention plan to prevent the same or similar incident from reoccurring and submit it to the Provider Oversight Contractor for review and approval.

  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.

- Prevention Plans Escalation timelines.

a. Provider Oversight Contractor will email the Case Manager and copy the Supervisor with a request to develop the Prevention Plan.

b. The Case Manager/Supervisor will have three business days to submit the Prevention Plan to the Provider Oversight Contractor for approval.

c. If not received, Provider Oversight Contractor will escalate to the Clinical Manager.

d. The Clinical Manager will have two business days to have it submitted the Provider Oversight Contractor.

e. If not submitted in two business days, the Provider Oversight Contractor will escalate to the Case Management Contract Manager with the required documentation. The Case Management Contract Manager will remedy the situation within three business days.

   a. Correspondence sent to Case Manager and Supervisor.

   b. Correspondence sent to Clinical Manager when no response was received.

- The Provider Oversight Contractor will review the prevention plan within five business days of submission.

- Once reviewed, the Provider Oversight Contractor will either approve the prevention plan or ask for changes. If the case management agency fails to respond to request for additional changes, the Provider Oversight Contractor will escalate to the Case Management Contract Manager within two business days. If the case management agency fails to place the prevention plan in the Person Centered Services Plan within 10 days, the Provider Oversight Contractor will escalate to the Case Management Contract

Manager on day twelve after the approval.

a. All correspondence to the case management agency will be forwarded to the Case Management Contract Manager

- The Case Management Contract Manager will remedy the situation within three business days.
- If not, resolved, Provider Oversight Contractor will reach out to Provider Oversight Contract Manager for a resolution.

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 members and/or who are hearing impaired.

5. Trend Analysis and Follow Up: The CMA will be required to submit data to ODM on a quarterly basis about the number and types of incidents reported. 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 protection from harm managers who monitor alerted incidents. These managers have three responsibilities: to provide oversight of incident alerts, 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 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 verifies 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.

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 assigned a 1.66 point value, each. Level Two Acuity individuals and all new (through first six months of enrollment) enrollees are assigned 2.22 point value, each. 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 by 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 ODM data systems:

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

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, Vehicle and Home 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.

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.

"**Home Modification services**" are environmental accessibility adaptations to structural elements of the interior or exterior of an individual's home, that are not otherwise available through any other funding source, and enable the individual to function with greater independence, avoid institutionalization and reduce the need for human assistance. ODM will approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.

Home Modification services do not include:

- changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the individual (i.e., carpeting, roof repair, central air conditioning, etc.);
- adaptations that add to the total square footage of the home;
- services performed in excess of what is approved pursuant to, and specified on, the individual's Person-Centered Services Plan;
- the same type of home modification for the same individual during the same 12-month calendar year, unless there is a documented need for the home modification or a documented change in the individual's medical or physical condition that requires the replacement;
- new home modifications or repair of previously approved home modifications that have been damaged as a result of confirmed misuse, abuse or negligence

The Ohio Home Care Waiver provides medically necessary supplemental adaptive assistive devices, vehicle and home 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.

4. The therapy evaluation can be prior authorized as the corresponding waiver service type and must be submitted as a prior authorization request through the MITS.

- 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 or home 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 individual's Medicaid eligibility in MITS prior to approving a home 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 (E).

3. 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.

4. The CMA must authorize the service to the provider who can complete the service as required and at the lowest-cost.

5. The CMA must contact or visit the individual within 10 calendar days to verify satisfaction with the device or modification, unless the device or modification meets the visit requirement for an event-based assessment as described in this Guide.

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

Supplemental adaptive assistive devices, vehicle and home modifications are subject to the specifications found in OAC rule 5160-46-04.

Appendix B

MCP Communication Protocol

Updated 11.1.17

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 one call).
- 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 as required.

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			
TBD Based on Contract Award			
Counties			
Ashtabula	Columbiana	Cuyahoga	Geauga
Lake	Lorain	Mahoning	Medina
Portage	Stark	Summit	Trumbull
Wayne			

COLUMBUS			
TBD Based on Contract Award			
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			
TBD Based on Contract Award			
Counties			
Allen	Auglaize	Butler	Champaign
Clark	Clermont	Clinton	Darke
Greene	Hamilton	Hancock	Hardin
Logan	Mercer	Miami	Montgomery

Preble	Putnam	Shelby	Van Wert
Warren			

MARIETTA				
TBD Based on Contract Award				
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 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 Debbie Gulley		800-582-7277	cmontgomery@aaa7.org dgulley@aaa7.org

8	Dawn Weber	Home Care Director	800-331-2644 x2360	Dweber@buckeyehills.org
9	Michele Bates Val Sampson	Consumer Care Division Director ADRN Director	740-435-4706 740-435-4932	mbates@aaa9.org 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 Jami Gilronan	Assessment PASSPORT/ALW	330-505-2300, ext 173 330-505-2322	l.eichelberger@aaa11.org 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 Berga 866-246-4356 ext 24224 or 419-205-3727 Kberga@CENTENE.COM OR Laura Paynter 866-246-4356 ext 24446 or 216-319-0481 lpaynter@centene.com	866-246-4358	866-549-8289
CareSource	Tonya Frank 937-469-1757 Tonya.Frank@caresource.com OR Alisha Frie 937-901-3918 Alisha.Frie@caresource.com	866-206-0554	866-206-0610
Molina Healthcare of Ohio	Deidre Palmer 800-642-4168 ext 216341 or 614-212-6341 Deidre.palmer@molinahealthcare.com	888-275-8750	888-275-8750
Paramount Advantage	Mary Crigger 419-887-2210 mary.crigger@promedica.org OR Christine Haydock 419-887-2239 Christine.Haydock@ProMedica.org	800-234-8773	800-891-2520
UnitedHealthcare Community Plan	Sarah M. Froehling 952-406-4877 sarah.froehling@uhc.com OR Diane McCutcheon 614-410-7352 Diane.mccutcheon@uhc.com	800-542-8630	800-895-2017

Appendix C

Ohio Map Regions