



Department of Medicaid

John R. Kasich, Governor

John B. McCarthy, Director

# HOME Choice Roles and Responsibilities

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Service Provider Training

Spring 2015





# Roles and Responsibilities: HOME Choice Team

	NF	Pre-Transition	Discharge	Community 1 <sup>st</sup> 90 days	Community 365 Participation days
NF Discharge Planner	●	—	●		
PTCM		●	●		
TC		●	—	●	
Community Support Coach			●	—	●
HC Case manager				●	—
MC Plans		●	—	—	●
My Care Ohio			●	—	●
Other HC Providers				●	—
MH/AoD Providers		●	—	—	●



# HOME Choice Team

LOTS of players but **one collective goal...**

to assist individuals to be as **successful as possible** through the **transition process** and in the **community**.



# Roles and Responsibilities

The Roles and Responsibilities for Service Providers are found in the:

- Provider Agreement
- OAC HOME Choice Rules



# Provider Agreement

- New agreements signed in February 2015
- Agreement on the HOME Choice website
- Contains specifics on:
  - Provider Requirements
  - Billing Information
  - Documentation Requirements
  - Service Delivery Information



# HOME Choice OAC Rules

- 5160-51-01
- 5160-51-02
- 5160-51-03
- 5160-51-04
- 5160-51-05 *rescinded*
- 5160-51-06

**Rules recently rewritten and went into effect  
February 1, 2015**



# HOME Choice OAC Rules

- 5160-51-01 – HOME Choice definitions
- 5160-51-02 – HOME Choice program application process, individual eligibility and enrollment
- 5160-51-06 – HOME choice billing terms, reimbursement rates and billing procedures for providers



# HOME Choice OAC Rules

- 5160-51-03 – Conditions of participation, and enrollment for providers
- 5160-51-04 – Definitions of covered services and provider qualifications



# Service Provider: Roles and Responsibilities

- Referral Process
  - Referral from Case Manager
    - (pre or post transition)
  - Communication with provider to include
    - individual name and situation
    - Address
    - Service goals
  - **Accept or decline referral**
    - Expectation to accept or decline in 3 business days



# Service Provider: Roles and Responsibilities

- Start of Service
  - Service Plan received via email from HOME Choice Operations
  - Note the service start date – Do not start to provide services prior to the start date on the service plan
  - **Initiate contact with the individual within five business days**



# Service Provider: Roles and Responsibilities

- Communication with the Case Manager
  - Routine communication
    - Before first visit
    - Regular intervals
  - Non-routine Reasons
    - **Incident of any type**
    - Moved
    - Money/bill paying issues
    - Declines your service consistently
    - Hospitalized or ER visits
    - Health or welfare issues



# Change in Status Form

- Complete this important communication tool
  - individual has moved
  - individual has been hospitalized
  - individual has been reinstitutionalized
  - individual has been incarcerated
  - individual has died
- Email or fax form to HOME Choice Operations & email the case manager the CIS form and additional information/details

# Change in Status Form

Ohio Department of Medicaid HOME CHOICE - CHANGE IN STATUS				
Participant Name (Last, First, MI)		Medicaid ID # (12 digits)		
<b>Section 1: PRE-ENROLLMENT TERMINATION</b> Complete Section 1 <u>only</u> if participant terminates or withdraws <u>before enrollment</u> into the program.				
Effective Date (mm/dd/yyyy)				
Reason (Check one below.)				
<input type="checkbox"/> Too physically ill		<input type="checkbox"/> Individual would not cooperate in care plan development		
<input type="checkbox"/> Too cognitively impaired		<input type="checkbox"/> Service needs greater than what could be provided in the community		
<input type="checkbox"/> Mental health needs exceed capacity of program to meet them		<input type="checkbox"/> Death		
<input type="checkbox"/> Guardian refused participation		<input type="checkbox"/> Individual did not choose MFP qualified residence		
<input type="checkbox"/> Could not locate appropriate housing arrangements		<input type="checkbox"/> Could not secure affordable housing		
<input type="checkbox"/> Individual changed his/her mind		<input type="checkbox"/> Other (You must specify.)		
<b>Section 2: INSTITUTIONALIZATION OR TRANSFER FROM ONE FACILITY TO ANOTHER AFTER ENROLLMENT</b> Complete Section 2 <u>only</u> if participant is admitted to a facility <u>after enrollment</u> into the program.				
Admission from <input type="checkbox"/> Residence <input type="checkbox"/> Another Institution				
Admission Date (mm/dd/yyyy)				
Facility Name				
Facility Address		City	State	Zip
Facility Type <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF/IID <input type="checkbox"/> Hospital <input type="checkbox"/> Residential Treatment Facility <input type="checkbox"/> Other (Specify.)				
Reason for Institutionalization (Check one.)				
<input type="checkbox"/> Acute care hospitalization followed by long term rehabilitation		<input type="checkbox"/> Loss of housing		
<input type="checkbox"/> Deterioration in cognitive functioning		<input type="checkbox"/> Loss of personal caregiver		
<input type="checkbox"/> Deterioration in health		<input type="checkbox"/> By request of participant/guardian		
<input type="checkbox"/> Deterioration in mental health		<input type="checkbox"/> Lack of sufficient community services		
<b>Section 3a: RESIDENCE INFORMATION</b> Complete Sections 3a and 3b if participant is discharged from a facility back into the community OR moves from one qualified residence to another after enrollment into the program. All fields are required information.				
Move Type <input type="checkbox"/> Discharge from Facility <input type="checkbox"/> Change in Residence		Effective Date (mm/dd/yyyy)		
Current Phone # (xxx-xxx-xxxx)		Residence Address		
City	County	State	Zip	
Is participant living with family? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Participant Name (Last, First, MI)		Medicaid ID # (12 digits)	
<b>Section 3b: RESIDENCE TYPE</b> Complete <u>both parts of section 3b</u> when participant moves from one qualified residence to another or is discharged from a facility.			
IS THE RESIDENCE			
<input type="checkbox"/> A residence in a community-based residential setting in which no more than 4 unrelated individuals reside? If so, indicate residence type. (Check one.)			
<input type="checkbox"/> Adult foster homes		<input type="checkbox"/> Adult family homes	
<input type="checkbox"/> Non-ICF/IID residential facilities		<input type="checkbox"/> Family foster home for children	
<input type="checkbox"/> Type 1 residential facilities		<input type="checkbox"/> Type 2 residential facilities	
<input type="checkbox"/> Treatment foster home for children		<input type="checkbox"/> Group homes for children	
<input type="checkbox"/> Medically fragile foster home		<input type="checkbox"/> Pre-adoptive infant foster home for children	
OR, is the residence			
<input type="checkbox"/> A home owned/rented by the participant			
<input type="checkbox"/> A home owned/rented by a family member or friend			
<input type="checkbox"/> An apartment/house leased by the participant (not assisted living)			
<input type="checkbox"/> An apartment leased by the participant (assisted living)			
HOUSING SUPPLEMENT(S) OBTAINED FOR HOME OR RESIDENCE (Check all that apply.)			
<input type="checkbox"/> Low income housing tax credit unit		<input type="checkbox"/> Unit subsidized with HOME funds	
<input type="checkbox"/> Section 202 unit		<input type="checkbox"/> Unit subsidized with Housing Trust Funds	
<input type="checkbox"/> Unit subsidized with CDBG funds		<input type="checkbox"/> VA subsidy	
<input type="checkbox"/> USDA Rural Development unit		<input type="checkbox"/> Funds for assistive technology for housing	
<input type="checkbox"/> Funds for home modification		<input type="checkbox"/> Section 811 unit	
<input type="checkbox"/> Housing Choice Vouchers		<input type="checkbox"/> Other (Describe.)	
<input type="checkbox"/> Not Applicable			
<b>Section 4: DISENROLLMENT FROM HOME CHOICE</b> Complete <u>only</u> if participant terminates the program after enrollment.			
Effective Date (mm/dd/yyyy)			
Reason (check one)			
<input type="checkbox"/> Moved to an institutional setting (Complete Section 2.)		<input type="checkbox"/> Completed 365 days of participation in program	
<input type="checkbox"/> Death of participant		<input type="checkbox"/> Suspended eligibility	
<input type="checkbox"/> Moved (Complete section 3a.)		<input type="checkbox"/> No longer needed services	
<input type="checkbox"/> Other (You must specify.)		<input type="checkbox"/> Loss of Medicaid	
<b>Section 5: COMPLETED BY</b>			
Name		Agency	Phone Ext
<p><b>Send completed form to:</b>  HOME Choice Operations Unit  Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports  PO Box 182709, 5<sup>th</sup> Floor  Columbus, OH 43218-2709</p> <p>Email: HOME_Choice@medicaid.ohio.gov  Fax Number: 614-466-6945</p>			



# Provider Agreement & OAC Rules

- General Requirements of a HOME Choice Service Provider
  - **Criminal Records check requirement**
  - Direct Staff Requirements
  - Provider is not under sanctions for Medicaid or Medicare programs
  - Abide by the Ohio code of Ethics
  - **Update HOME Choice with changes in ownership, phone number, address and email address**
  - Attend trainings
  - **HIPAA Requirements and honoring confidentiality**
  - And much more...



# Provider Agreement & OAC Rules

- Conditions of Participation
  - No behavior that causes or may cause physical, verbal mental or emotional abuse to the individual
  - **Cannot be designated as an authorized rep, Payee, POA or guardian**
  - No accepting of money or anything of value
  - Must not take individual to the service provider's home or take children, pets or friends to the individual's home
  - **Cannot deliver services while individual hospitalized, institutionalized or incarcerated**
  - And much more...

# Provider Agreement & OAC Rules

- Information about Service Delivery
  - Delivered in a **prompt and professional manner**
  - HC is not Medicaid and cannot deliver Medicaid services
  - **According to the Service Plan**
  - Rendered by the provider and not sub-contracted without the prior written consent of ODM
  - Embrace the individual's self determination
  - Follow **incident reporting requirements**
  - Counties selected by provider
  - And much more...



# Provider Agreement & OAC Rules

- Information about Documentation
  - Separate file per individual
  - Can be electronic or paper
  - Chronological records of contacts with individual or on behalf of the individual: Notes with dates & signatures
    - Method
    - With whom
    - Content
    - Date and time
  - Service plan
  - Shall be retained for six years
  - Submit to ODM within 30 days in case of an audit



# Provider Agreement & OAC Rules

- Information about the role of HOME Choice Provider Relations
  - Can place a provider on probationary status because of concerns about performance
  - ODM requests cooperation during provider monitoring activities
  - Either party can terminate with 30-day written notice
  - Failure to meet requirements may result in termination



# Provider Agreement & OAC Rules

- Information about billing for services
  - Billing definitions
  - Billing codes
  - Not billed or reimbursed like Medicaid services
  - Payment is in full
  - Rates and units in 5160- 51-06
  - If overpayment, the amount will be deducted from future payments
  - And much more...



# HOME Choice Nursing

- Can be delivered by an agency or non-agency
- By an RN or LPN under supervision of a RN
- Intermittent services in nursing scope
- Often used as a bridge for waiver services
- Maintain a clinical record that includes
  - All plans of care
  - type, frequency, scope and duration of services
  - Documentation of MD verbal orders
- And much more...



# Community Support Coach

- **Only** service that can start while the individual is still in the NF
- During pre-transition cannot be the same person as the TC
- Serviced delivered:
  - Peer support
  - Goal setting
  - Managing multiple tasks
  - Problem solving
  - Identifying community resources
  - Assistance with job searching
  - And much more...



# Independent Living Skills Training

- Focuses on Community Living Skills
  - Home management skills
    - Shopping and meal planning
    - Housekeeping and laundry
  - Money management skills
    - Bill paying
    - Banking
  - Managing transportation
    - Buses and community resources
  - Knowing how to ask for help
  - And much more...



# Social Work/Counseling Service

- Delivered to promote the individual's physical, social and emotional well-being
- Help develop a stable and supportive environment
- Crisis intervention
- Grief counseling
- Conduct a psycho-social assessment that also includes financial and environmental status
- Develop a treatment plan to be shared with individual and case manager
- And much more...



# Nutritional Consultation Service

- Provides individualized guidance
- Assess need for adaptive equipment
- Provide nutritional education
- Develop a nutritional intervention plan with the assistance of individual, case manager, physician and other relevant service providers
- And much more...



# Communication Aid Service

- Devices to assist with hearing, speech or vision impairments
- Other mechanical and electronic devices
- New technologies that achieve the service objective



# Respite

- Provide a individual not able to take care of self due to the temporary absence of primary caregiver
- May be provided:
  - In-home
  - Out-of-home
  - Day camp setting



# Service Animals

- Animals trained to perform tasks that the individual cannot perform for themselves
- Can assist with the expenses associated with their use
  - Housing, feeding, upkeep and medical care
  - Equipment and supplies
  - Transportation to the vet



# Contact Information

**Phone Number:** 1-888-221-1560

**Email:** HOME\_CHOICE@medicaid.ohio.gov

**Website:** <http://medicaid.ohio.gov/HomeChoice>

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