

The Review of the Provider Manual & Workflow Process

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Bureau of Long-term Care Services and Supports
2/22/16



Discharge Planning & Transition Team

| | Transition Planning in the Facility | Discharge Day | Community (365 Participation Days) |
|---|--|--|------------------------------------|
| Individual, family, guardian | [Arrow spanning all three phases] | | |
| Pre-Transition Case Manager | [Arrow in Transition Planning] | | |
| Transition Coordinator | [Arrow spanning Transition Planning and Discharge Day] | | |
| Community Support Coach | | [Arrow spanning Discharge Day and Community] | |
| HOME Choice Case Manager or Waiver Case Manager | | [Arrow spanning Discharge Day and Community] | |
| Managed Care Plans | [Arrow spanning all three phases] | | |
| HOME Choice Service Providers | | | [Arrow in Community] |
| MI/SUD Providers | [Arrow spanning all three phases] | | |

HOME Choice Services are Identified

- How are HOME Choice Services added?
 - » The HOME Choice Case Manager (HCCM) meets with the individual to identify possible services.
 - » HCCM will contact service provider with referral information.
 - » Authorized Service plan is sent to provider

Authorized email from HOME Choice

Mock Service Authorization Email

HOME Choice providers are only authorized to provide services for the date span (begin & end dates) indicated on the Service Plan. HOME Choice providers shall not provide services without receipt of an approved copy of the HOME Choice Service Plan designating them as the provider of that service. Unauthorized service dates submitted for payment will be returned unpaid. Contact the HOME Choice Case Manager if there are any questions.

The anticipated completion date for this participant is 03/30/2016.

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HOME Choice Service Plan



Ohio Department of Medicaid
 Demonstration and Supplemental Services Authorization
 For HOME Choice Services ONLY

| Participant Name and Contact Information Name Address City, State, zip Phone: 123-456-7890 Guardian: Guardian Phone: | | Medicaid #: 123456789123 Participant Start Date: 8/22/2013 (HC APPROVAL DATE) Participant End Date: CLA: Karen Jackson 1) Case Management Agency Name, Phone Number: CareStar, Bobbie Malone 456-789-0123 (2) Managed Care/MyCare Ohio Plan & phone number: | | |
|--|--|---|--------|--|
| Date(s) Begin and/or End date | HOME Choice Service Code | Span Units(s) | Cost | HC Provider Number/ Provider Name, Phone |
| 8/2/2015 – 1/8/2016 | HC018 – Pre-Transition Case Management | 1 | \$0.00 | HC1609 – CareStar, Inc., 800-616-3718 |
| 9/4/2015 – | HC010 – Transition Coordinator | 1 | \$0.00 | HC1501 – Jefferson Behavioral Health System, |
| 1/8/2014 – 5/31/2014 | HC015 – Home Choice Case Management | 1 | \$0.00 | HC1611 – CareStar, Inc., 800-616-3718 |
| 1/14/2014 – (3) | HC003 – Independent Living Skills Training | 576 (4) | \$0.00 | HC1512 - Jefferson Behavioral Health |
| 1/14/2014 – (3) | HC004 – Community Support Coaching | 288 (5) | \$0.00 | HC1512 - Jefferson Behavioral Health |
| 1/14/2014 – (3) | HC005 – Social Work/Counseling Services | 144 (6) | \$0.00 | HC1512 - Jefferson Behavioral Health |

- (1) Community Living Administrator
- (2) Case Management Contact Information (Including phone number)
- (3) Begin Date authorizing Service Providers
- (4) Number of units authorized for Independent Living Skills Training (1-Unit = 15 minutes)
- (5) Number of units authorized for Community Support Coaching (1-Unit = 15 minutes)
- (6) Number of units authorized for Social Work Counseling (1-Unit = 15 minutes)
 - Services cannot begin prior to the Begin Date.
 - Services cannot continue beyond the End Date.
 - HCCM responsibility to contact service providers prior to Service Plan submission. Providers will receive additional documentation about the individual which may include: the Community Readiness Tool, Eligibility Checklist, and Enrollment Form.
 - Providers receive updated service plans whenever they a revision is made by HOME Choice Operations.
 - Community Support Coaching is the only service that may be authorized prior to discharge.

Roles & Responsibilities as a Provider

- » Ohio Administrative Code (Link: <http://codes.ohio.gov/oac/>)
 - 5160-51-03: Conditions of participation and enrollment of providers
 - 5160-51-04: Definitions of covered services and provider qualifications
 - 5160-51-06: Bill procedures and reimbursement rates

- » Provider Agreement

Cont.: Roles & Responsibilities as a Provider

» General Requirements of providers

- Annual BCI criminal records check (Non-Agency Providers)
- Provider is in good standing (Medicaid and Medicare Programs)
- All licenses must be current (Nursing, Social/work counseling, Nutritional Consultation)
- Attend annual trainings
- Update any changes to ownership, name, address, phone number, or email addresses

Cont.: Roles & Responsibilities as a Provider

» Conditions of participation

- Be professional/courteous in your interactions with participants
- Provider cannot be designated one of the following
 - Authorized representative
 - Payee
 - Power of Attorney or Guardian
 - Accept money or be designated on any bank accounts or credit cards
- Services cannot be delivered if the individual is hospitalized, institutionalized, or incarcerated

Service Delivery of Providers

- » Services need to be delivered in a prompt and professional manner
- » Services delivered according to service plan and guidance from HCCM
- » Service cannot be sub-contracted without ODM consent
- » Embrace the individuals self determination
- » Follow incident reporting requirements

Be mindful of the individual's surroundings

- » Does the individual have food?
- » Does the individual look under the influence of any substances
- » There are bills left un-open, or an eviction notice posted on the door
- » How is the individuals medication?
- » His/her Mental health seems to be deteriorating

On-going Communication with Case Manager

- » Routine Communications

- » Non-Routine reasons to communicate
 - Incident of any type
 - Individual has moved or is unable to contact
 - Refuses to cooperate with you as a provider
 - Hospitalized and ER visits
 - Safety and health issues
 - Substance uses
 - Overall concerns and living conditions of the individual

HCCM/CSC/ILST Chart

| HOME Choice | HOME Choice Case Management (HCCM) | Community Support Coach (CSC) | Independent Living Skills Training (ILST) | HOME Choice Case Management (HCCM) | Community Support Coach (CSC) | Independent Living Skills Training (ILST) |
|---------------------------------------|---|--|---|---|---|--|
| What is the service? | Support by working with the individual collaboratively to help review, plan, assist, and advocate for options and services that best meet the needs of the individual in the community. | Support for community living through one-on-one coaching that guides, educates and empowers HOME Choice Individuals and their families. | Training develops or increases skills, knowledge and abilities needed to successfully live on one's own. | | <ul style="list-style-type: none"> Evaluating health options and strategies Responsibility for recovery services goals | <ul style="list-style-type: none"> Managing and accessing medical supplies Crisis care/recovery services How to link to doctors and dentists Learning about & getting devices that help the individual live independently Preparing for emergencies Learning how and when to take medicine |
| When is the service provided? | May start prior to discharge in order to participate in discharge planning and on the day of discharge. Service begin date is based on authorization by HOME Choice Operations. HCCM continues throughout the 365 days of participation. | Before, during and after they move into the community | During the 365 day participation period | | | |
| How is the service provided? | Individuals not on a waiver will be authorized HCCM who will meet with and contact the individual on a regular basis. | One-on-one with the participant and/or their family | Training services can be delivered to an individual or in a group or classroom setting | Community Activities: <ul style="list-style-type: none"> Maintain contact with service providers Assess if additional services are needed Maintain contact with the individual monthly Facilitate at least one post-discharge meeting with TC, individual, and other providers within the first 80 days of discharge Responsible for incident reporting Assist individual with housing recertification and rental assistance Inform all service providers when participant is within 30 days of completing his 365 day participation period. Facilitate final meeting with individual, and providers prior to 365 participation period is complete | Home management skills: <ul style="list-style-type: none"> Finding new and different ways to do things Developing problem solving strategies Learning to break projects down into tasks | Home management skills: <ul style="list-style-type: none"> Personal shopping Housekeeping and laundry Grocery shopping, cooking and meal planning How to use appliances |
| What type of help is provided? | Pre-Transition: <ul style="list-style-type: none"> Discharge planning meeting Responsibilities on day of discharge Determine post-discharge HOME Choice and state plan services Ensure HC services are in place if waiver or state plan services cannot start at discharge | Financial management skills: <ul style="list-style-type: none"> Assisting with employment goals Evaluating employment skills/potential Developing job finding strategies Increasing interview skills Developing application and resume writing | Financial management skills: <ul style="list-style-type: none"> Finding a bank and setting up an account Paying bills and taxes Creating and sticking to a budget Using a bank (ATM) machine | | Personal skills training: <ul style="list-style-type: none"> Developing strategies to obtain goals Creating short and long range goals | Personal skills training: <ul style="list-style-type: none"> Dressing and bathing Making and keeping appointments |
| | Day of Discharge: <ul style="list-style-type: none"> Be available and present for assistance and support on moving day Provide 24 hour contact information and documentation of a backup plan for participant | Improving social skills: <ul style="list-style-type: none"> Making educated choices Evaluating options and consequences Accepting responsibility for decisions | Improving social skills: <ul style="list-style-type: none"> How to be a good neighbor and/or roommate When and how to ask for help | | Community living skills: <ul style="list-style-type: none"> Investigating community resources Anticipating and planning for future needs | Community living skills: <ul style="list-style-type: none"> How to read a bus schedule, call for transportation Identifying and accessing community resources Job training and how to search for and find a job Safety skills in the community |
| | | Health management skills: <ul style="list-style-type: none"> Setting health goals Making informed health decisions Accepting health responsibilities | Health management skills: <ul style="list-style-type: none"> Nutrition: what to eat, how much to eat, when and how often How to talk to the doctor | | | |

Provider Documentation

» Review Rule:

- OAC 5160-51-03 and Provider Agreement
- All records must be maintained for a period of 6 years (From the date of service)

» Create individual files for each participant

- Copy of Authorized service plan
- Supporting Documentation/Case Notes should include
 - Provider name
 - HOME Choice provider number
 - Address
 - Phone number
 - Case notes (Description of what took place9What); location (Where); and with whom
 - Dates and signatures of the provider and individual
- Any other supporting documentation

Emergency Rent and Utility Assistance

» Emergency Rent and Utility Assistance

- Can ONLY be use for Rent or Utility Assistance
 - Must be a valid reason for needing assistance or request will be denied
- The HCCM and Transition Coordinator facilitate any need of assistance
- Service Provider should communicate any concerns to the HCCM to address issues.

Incident Reporting

» What is considered an incident?

- “An incident is a situation that may cause harm, have the potential to cause harm or has caused harm to an individual. They are alleged, suspected or actual events that are not consistent with routine care or routine service delivery”.

» ANY incident discovered during a contact/visit should be reported by the provider to the case manager immediately

» Examples of possible incidents (Refer to your Manual where ALL incidents are listed):

- Abuse
- Exploitation
- Involvement in criminal justice system
- Loss of income
- Neglect
- Accident/injury
- Hospitalization
- Location unknown

FORMS- Change In Status

Ohio Department of Medicaid HOME CHOICE - CHANGE IN STATUS

| | | | |
|--|---|------------------------------------|--------------|
| Participant Name (Last, First, MI) [] | | Medicaid ID # (12 digits) [] | |
| Section 1: PRE-ENROLLMENT TERMINATION <i>Complete Section 1 only if participant terminates or withdraws before enrollment into the program.</i> | | | |
| 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.) [] | | |
| Section 2: INSTITUTIONALIZATION OR TRANSFER FROM ONE FACILITY TO ANOTHER AFTER ENROLLMENT <i>Complete Section 2 only if participant is admitted to a facility after enrollment into the program.</i> | | | |
| Admission from | | | |
| <input type="checkbox"/> Residence <input type="checkbox"/> Another Institution | | | |
| Admission Date (mm/dd/yyyy) [] | | | |
| Facility Name [] | | | |
| Facility Address [] | | City [] | State [] |
| Facility Type | | Zip [] | |
| <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 | | |
| Section 3a: RESIDENCE INFORMATION <i>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.</i> | | | |
| Move Type | | Effective Date (mm/dd/yyyy) [] | |
| <input type="checkbox"/> Discharge from Facility <input type="checkbox"/> Change in Residence | | | |
| 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) [] | |
| Section 3b: RESIDENCE TYPE <i>Complete both parts of section 3b when participant moves from one qualified residence to another or is discharged from a facility.</i> | | | |
| 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 | | | |
| Section 4: DISENROLLMENT FROM HOME CHOICE <i>Complete only if participant terminates the program after enrollment.</i> | | | |
| 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 | | |
| Section 5: COMPLETED BY | | | |
| Name [] | Agency [] | Phone [] | Ext [] |
| <p>Send completed form to: HOME Choice Operations Unit Ohio Department of Medicaid/Bureau of Long-Term Care Services and Supports PO Box 182709, 5th Floor Columbus, OH 43218-2709</p> <p>Email: HOME_Choice@medicaid.ohio.gov Fax Number: 614-466-6945</p> | | | |

Fiscal Management Agency – Morning Star

- Service Claims are to be submitted to Morning Star Financial Services
 - » You can submit the following ways
 - Email (MS-Ohexpenses@morningstarfs.com)
 - Online Submission: <http://morningstarfs.com/pages/HOMEChoicesandsuccess>
 - Fax: 855-233-5233
 - Mail:
 - Morning Star Fiscal Services
 - 9400 Golden Valley Rd.
 - Golden Valley, MN 55427
- Morning Star Portal
 - » Username and password

Additional Information in the Provider Manual

- HOME Choice Community Services
- Appendix
 - » HOME Choice Operations Contact Information
 - » Roles & responsibilities Chart (HCCM vs. CSC vs. ILST)
 - » Roles & Responsibilities Chart (PTCM, TC, and HCCM)
 - » Provider Rate Chart
 - » Incident Types & Definitions

Cont.: Additional Information in the Provider Manual

- Resources:
 - » Forms & Tools
 - » Mock Service Plan
 - » Service Claim Request Form
 - » Change In Status
 - » Website Information
 - » Training Updates & Resources
 - » Ohio Administrative Code
 - » Provider Agreement

What are ways I can become a knowledgeable provider in the HOME Choice Program?

- » HOME Choice Service Provider Manual
 - Review and use the manual often.

- » Attend the Annual Training sessions

- » Review website monthly for updates and information
 - HOME Choice Trainings & Updates Page
 - Website Front Page:
<http://medicaid.ohio.gov/FOROHIOANS/Programs/HomeChoice.aspx>

- » Don't be shy. Communication is key for HOME Choice
 - Communicate with the HOME Choice Case Manager (HCCM) or Waiver case manager
 - Report Incidents immediately

Thank you for your time

Brock Robertson

Provider Administrator

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614-752-3577

**MAKING
OHIO
BETTER**

