TO BE RESCINDED

5160-58-01 **MyCare Ohio plans: definitions.**

(A) The definitions set forth in rule 5160-26-01 of the Administrative Code apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code, except that the following definitions apply to MyCare Ohio:

(1) "Authorized representative" has the same meaning as in rule 5160:1-1-55.1 of the Administrative Code.

(2) "Covered services" means the set of required services offered by the MyCare Ohio plan pursuant to rule 5160-58-03 of the Administrative Code.

(3) "Eligible individual" also known as "potential enrollee" means a medicaid recipient who is a legal resident of the MyCare Ohio program service area and who is subject to mandatory enrollment or may voluntarily elect to enroll in a MyCare Ohio plan, but is not yet an enrollee of a specific MyCare Ohio plan.

(4) "Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" has the same meaning as in rule 5123:2-7-01 of the Administrative Code.

(5) "Medicaid" means medical assistance as defined in section 5162.01 of the Revised Code.

(6) "Medically necessary services" means services provided in accordance with medicaid law and regulations, in accordance with clinical coverage guidelines specified in agency 5160 of the Administrative Code.

(7) "Member," also known as "enrollee," means a medicaid eligible beneficiary that has selected MyCare Ohio plan membership or has been assigned to a MyCare Ohio plan for the purpose of receiving health care services.

(8) "Nursing facility (NF)" has the same meaning as in section 5165.01 of the Revised Code.

(9) "Oral interpretation services" means services provided to a limited-reading proficient eligible individual or member to ensure that he or she receives MyCare Ohio plan information in a format and manner that is easily understood by the eligible individual or member.

(10) "Oral translation services" means services provided to a limited-English proficient eligible individual or member to ensure that he or she receives MyCare Ohio plan information translated into the primary language of the eligible individual or member.

(11) "PACE" has the same meaning as in rule 5160-36-01 of the Administrative Code.

(12) "PCP (primary care provider)" means an individual physician (medical doctor or doctor of osteopathy), certain physician group practice, a physician assistant in accordance with rule 5160-4-03 of the Administrative Code under the supervision of the qualifying treating physician, or advanced practice nurse as defined in section 4723.43 of the Revised Code, or advanced practice nurse group practice within an acceptable specialty, contracting with a MyCare Ohio plan to provide primary care services. Acceptable specialty types include family/general practice, internal medicine, pediatrics, geriatrics and obstetrics/gynecology (OB/GYN).

(13) "Premium" means the monthly payment amount per member to which the MyCare Ohio plan is entitled as compensation for performing its obligations in accordance with Chapter 5160-58 of the Administrative Code and/or the provider agreement with ODM.

(14) "Provider" means a hospital, health care facility, physician, dentist, pharmacy, HCBS provider or otherwise licensed, certified, or other appropriate individual or entity, that is authorized to or may be entitled to reimbursement for health care services rendered to a MyCare Ohio plan's member.

(15) "Provider agreement" means a formal agreement between ODM and a MyCare Ohio plan for the provision of medically necessary services to medicaid members who are enrolled in the MyCare Ohio plan.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code and paragraph (A) of this rule, the following definitions apply to Chapter 5160-58 of the Administrative Code:

(1) "Assessment" means a comprehensive evaluation of an individual's medical, behavioral health, long term services and supports, and social needs. Results of the assessment process are used to develop the integrated, individualized care plan, inclusive of the waiver services plan.

(2) "Creditable insurance" or "creditable coverage" means health insurance

coverage as defined in 42 U.S.C. 300gg-3(c) (October 17, 2013).

(3) "Dual benefits (also referred to as "opt-in") member" means a member for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.

(4) "Financial management service" or "FMS" means a support that is provided to waiver participants who direct some or all of their waiver services. When used in conjunction with the employer authority, this support includes, but is not necessarily limited to, operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes, but is not necessarily limited to, paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.

(5) "HCBS" means home and community-based services.

(6) "Health and welfare" means a requirement that necessary safeguards are taken to protect the health and welfare of individuals enrolled on HCBS waivers. It includes the following:

(a) Risk and safety planning and evaluations;

(b) Critical incident management;

(c) Housing and environmental safety evaluations;

(d) Behavioral interventions;

(e) Medication management; and

(f) Natural disaster and public emergency response planning.

(7) "Individual care plan" means an integrated, individualized, person-centered care plan developed by the member and his or her MyCare Ohio plan's trans-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

(8) "Medicaid consumer hotline" means an organization or individual under contract with or designated by ODM to provide MyCare Ohio plan

information and enrollment services to eligible members.

(9) "Medicaid only (also referred to as "opt-out") member" means a member for whom a MyCareOhio plan is responsible for coordination and payment of medicaid benefits.

(10) "MHAS" means the Ohio department of mental health and addiction services.

(11) "MyCare Ohio plan" means a health insuring corporation contracted to comprehensively manage medicaid benefits for medicare and medicaid eligible members, including home and community-based services. MyCare Ohio plans are also managed care plans in accordance with rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, a MyCare Ohio plan does not include entities approved to operate as a PACE site.

(12) "NF-based level of care" means the intermediate and skilled levels of care, as described in rule 5160-3-08 of the Administrative Code.

(13) "Participant direction" means the opportunity for a MyCare Ohio waiver member to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

(14) "Significant change event" is a change experienced by a member that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the waiver-enrolled individual has not received MyCare Ohio waiver services for ninety calendar days.

(15) "Trans-disciplinary care management team" means a team of appropriately qualified individuals comprised of the member, the member's family/caregiver, the MyCare Ohio plan manager, the waiver service coordinator, if appropriate, the primary care provider, specialists, and other providers, as applicable, that is designed to effectively meet the enrollee's needs.

(16) "Waiver services plan" is a component of the care plan that identifies specific goals, objectives and measurable outcomes for a waiver-enrolled member's health and functioning expected as a result of HCBS provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the individual. At a minimum, the waiver services plan shall

include:

(a) Essential information needed to provide care to the member that assures the member's health and welfare;

(b) Signatures indicating the member's acceptance or rejection of the waiver services plan; and

(c) Information that the waiver services plan is not the same as the physician's plan of care.

Effective:

Five Year Review (FYR) Dates: 04/14/2017

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, 5166.02, 5167.02
Rule Amplifies:	5164.02, 5166.02, 5167.02
Prior Effective Dates:	3/1/14