

### Current Care Management Definitions

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
PASSPORT	AGE	Age 60+ NF LOC	28,000	AAA or CSS	From Waiver Instructions page 109 case management usually entails (but is not limited to) conducting the following functions: <ul style="list-style-type: none"> <li>• Evaluation and/or re-evaluation of level of care;</li> <li>• Assessment and/or reassessment of the need for waiver services;</li> <li>• Development and/or review of the service plan;</li> <li>• Coordination of multiple services and/or among multiple providers;</li> <li>• Linking waiver participants to other Federal, state and local programs;</li> <li>• Monitoring the implementation of the service plan and participant health and welfare,</li> <li>• Addressing problems in service provision;</li> <li>• Responding to participant crises</li> </ul>
Choices	AGE	Age 60+ NF LOC	224	AAA or CSS	Same as above
Assisted Living	AGE	Age 21+ NF LOC	300	AAA or CSS	Same as above
Ohio Home Care	ODJFS	Up to age 60 NF LOC	7,730	CareStar	OAC 5101:3-45-01 (J) defines case management services as administrative activities that link, coordinate and monitor the services and resources provided to a consumer enrolled on an ODJFS-administered waiver. ODJFS may contract with other entities to perform one or more of these functions.
Transitions Waiver	ODJFS	ICFMR LOC previously on the Home Care Waiver	3,000	Care Star	Same as Ohio Home Care
Transitions II Aging Carve out	ODJFS	Age 60 + and previously enrolled on Home Care	1,270	CareStar	Same as Ohio Home Care
Level One Waiver	DMR	ICFMR LOC	4,800	County Boards of MRDD	<a href="#"><u>5101:3-48-01 Medicaid coverage of targeted case management services provided to individuals with mental retardation and developmental disabilities.</u></a>

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
					<p>(7) "Targeted case management" means services which will assist individuals in gaining access to needed medical, social, educational and other services as described in this rule in accordance with section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective January 1, 2006. Targeted case management is also referred to as medicaid case management.</p> <p>(D) Reimbursable activities.</p> <p>(1) Medicaid services listed in paragraph (D) are reimbursable only if provided to or on behalf of a medicaid eligible individual as defined in paragraph (C) of this rule and by qualified providers as defined in paragraph (E) of this rule. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid reimbursable TCM services are:</p> <p>(a) Assessment. Activities...:</p> <p>(i) Activities performed to make arrangements to obtain from therapists and appropriately qualified persons the initial and on-going assessments of an eligible individual's need for any medical, educational, social, and other services.</p> <p>(ii) Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for HCBS waiver services administered by ODMRDD.</p> <p>(iii) Activities related to recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for HCBS waiver services administered by ODMRDD.</p> <p>(b) Care planning - Activities related to ensuring the active participation of the eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the eligible individual. These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).</p> <p>(c) Referral and linkage -Activities that help link eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services.</p>

Program or Service	Administrative Agency	Population Served	Approx. #s Served	Care Mangmnt Entity	Regulation/definition
					<p>(d) Monitoring and follow-up:</p> <p>(i) Activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible individual.</p> <p>(ii) Conducting quality assurance reviews on behalf of a specific eligible individual and incorporating the results of quality assurance reviews into amendments of an ISP.</p> <p>(iii) Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and MUIs and integrating prevention plans into amendments of an ISP.</p> <p>(iv) Ensuring that services are provided in accordance with the ISP and ISP services are effectively coordinated through communication with service providers.</p> <p>(v) Activities and contacts that are necessary to ensure that guardians and eligible individuals receive appropriate notification and communication related to unusual incidents and MUIs.</p> <p>(e) State hearings-Activities performed to assist an eligible individual in preparing for a state hearing related to the reduction, termination or denial of a service on an ISP.</p>
Individual Options	DMR	ICFMR LOC	11,800	County boards of MRDD	Same as above

Waivers are required to provide care/case management sometimes also called service coordination or service and support administration. The state has three options related to the manner in which care management is provided; it may provide case management as a service within the waiver, or as a State plan service (Targeted Case Management) under §1915(g)(1) of the Act and/or as an administrative activity, performed by state or local government employees or contractors. States may use a core service definition proposed by CMS or develop their own definition which would need to be approved by CMS.

ODJFS and Aging have elected to provide care management as an administrative function; ODMRDD has elected to provide care management as a service which is in the state plan.

Social Security Act defines case management services offered under the state plan as- (2)<sup>[128]</sup> For purposes of this subsection, the term “case management services” means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

**Other Definitions of Care Management**

Program and Services	Administrative Agency	Pop. Served	Approx. #s Served	“Care Management” Entity	Regulation/definition
Managed Care	JFS			Managed Care Plan	<p>OAC 5101:3-26-03.1</p> <p>8) MCPs must provide case management (CM) services to coordinate and monitor treatment rendered to members with specific diagnoses or who require high-cost or extensive services.</p> <p>(a) MCPs must notify all members of the CM services they may be eligible to receive;</p> <p>(b) The MCP’s CM program must include and document the following, at a minimum:</p> <p>(i) Screening and identification of members who potentially meet the criteria for case management;</p> <p>(ii) Assessment of the member’s health condition to confirm the results of the screening and determine the need for case management;</p> <p>(iii) Notification to the member and their PCP of the member’s enrollment in the MCP’s case management program; and</p> <p>(iv) Development and implementation of a treatment plan for members in case management.</p> <p>(c) MCPs must report case management program-related data to ODJFS, as required</p>