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What You Need to Know: Understanding the Basics of Being an Assisted Living Waiver Provider

Presented by: Angie Jenkins, Easter Keller-Dixon, Tabitha King, and Brenda Lynne

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Brief History on The Aging Network

- Federal legislation signed into law in 1965
- It was part of President Lyndon B. Johnson's "Great Society" initiative with the goal of supporting older adults to live at home and in the community with dignity and independence as long as possible.
- It created the federal, state and local organizational infrastructure that makes up the Aging Network.

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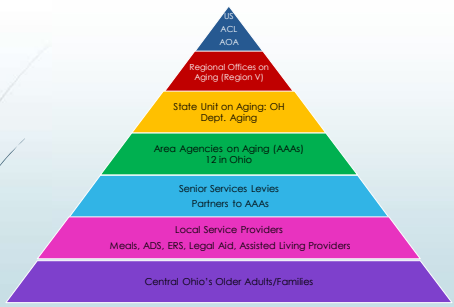

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What are Area Agencies on Aging? (AAA)?

- Created by the Older Americans Act, Federal legislation enacted in the Johnson Administration in 1965 (last reauthorized in 2020) to administer and fund programs & advocate on behalf of older adults, adults with disabilities & families.
- All over the USA and territories (622)
- All serve multi-county regions

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Central Ohio Area Agency on Aging

- COAAA is an Aging and Disability Resource Network (ADRN)
- **Agency Mission**: The mission of the Central Ohio Area Agency on Aging (COAAA) is to inform and support people as they navigate the experience of aging or disability
- **Agency Vision**: Our vision is for individuals and families to have knowledge and access to the information and resources they need to live life with dignity and independence.
- **Agency Values**
  - Respect for individual choice and self-direction
  - Quality care, case management, assessment, and referral services
  - Advocacy for individuals and policies to improve the lives of older adults, people with disabilities, and their caregivers

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What do AAAs do?

- Fund Community Based Services (Older Americans Act Title III)
- Provide Information, Assistance, and education about aging issues and programs
- Advocate on behalf of older adults and adults with disabilities and their families
- Administer Medicaid Waiver Programs to keep people at home

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COAAA Services...

COAAA
- Celebrating 50 Years of Service
- Employing over 400 Staff

ADRN
- Screening, Pre-Admission Review, Assessment, Community Education & Outreach, and Provider Relations.

Case Management
- CM over 10,000 individuals in 2023. Translating to over 160 home visits per day.
  - Medicaid Waiver- PASSPORT, Assisted Living Waiver, MyCare
  - Non-Waiver- Sr. Options

- **Clinical Innovations**
  - Care transitions, Humana Positive Choices, Veteran PDP, Social Determinants of Health, Volunteer Guardian Program

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How do I apply?

- You must start through the Ohio Department of Aging (ODA) at https://aging.ohio.gov
- Ensure that you are prepared to apply by following ODA's "Prior to Application" steps 1-5
- Once you initiate an application, you have 10 days to submit it before it expires
- Non-refundable application fee of $688
- Once your application is submitted, you must upload any required supplemental documentation within 90 days before it expires

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What happens next?

- Once ODA has approved your application and supplemental documentation, they will assign your facility to your local Area Agency on Aging (AAA) for a pre-certification review
- Someone from your AAA's Provider Relations department will come to your facility to review your space, policies and procedures, personnel charts, and clinical documentation to assess your readiness to be an ODA-waiver certified provider
- If you do not yet meet all of ODA's requirements, the AAA staff will send you a summary letter detailing what you need to do/submit to achieve compliance
- The AAA staff will make a certification approval or denial recommendation to ODA based on the outcome of the pre-certification review

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How long does the process take?

- Unfortunately, there is no definitive answer. It can take as little as 2 months but up to 6+ months
- Once the AAA receives assignment of your facility from ODA, we have 60 days to complete the pre-certification review process (schedule → visit → write and send summary → collect and review evidence of compliance → make recommendation to ODA)
- Once we make our recommendation to ODA, we just need to wait for their response. This timeline varies based on their work flow and other factors
- Once ODA informs the AAA that you've been approved for certification, the contracting process with the AAA begins

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What is the contracting process like?

- The contracting process is likely different at each AAA, so I will speak only to AAA6's process
- Since we are part of the City of Columbus Recreation and Parks Department, each of our providers has to complete City of Columbus vendor registration. Our office assistant will provide this information to you along with a W9
- Incorrect vendor registration and/or W9 is the most common reason the contracting process gets delayed!
- Once this step is complete (and correct), we will forward all necessary information to our fiscal department who will draft a contract
- When your contract (also called Provider Agreement) is finalized, you may start accepting referrals as of the contract effective date unless informed otherwise
- The clinical staff will be notified that you are a new provider and now able to accept referrals
- You will receive information on how to bill along with your contract. You will receive a link to register for our billing system once your first service authorization is awarded
- AAA6 works with Aetna and Molina for MyCare – you will have to contact those organizations independently to obtain contracts with them

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Waiver Service Rate

- **Room and Board**: $893/month. This is determined by the current SSI rate minus $50 dollars that the individual gets to keep monthly for personal expenses
- **Client liability:** Any income that exceeds room and board rate plus the $50 dollars goes to AL towards cost of care
  - Example: Income $1200/month. Room and Board is $893/month
    - Personal Spending is $50/month
    - Cost of Care/Liability would then be $257/month
- **Basic Care Rate: $130/day**
  - This is the rate the majority of individuals will fall into.
- **Critical Access Rate: $145/day**
  - This rate is reserved for facilities who have an average of 50 percent of the resident in their facility enrolled in Medicaid during the preceding state fiscal year through either the Assisted Living Program, MyCare Ohio, or PACE.
- **Memory Care Rate: $155/day**
  - This rate is reserved for consumers with a Dementia dx in an active accredited memory care facility. These facilities must meet additional criteria as set forth by ODA to bill at this rate.

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Resident Enrollment Process

- There are two assessments required for an individual to qualify for the Assisted Living Waiver.
  1. Area Agency on Aging Assessment
     - Requires Intermediate Level of Care (nursing home level of care)
     - Protective Level of Care vs Intermediate level of Care
  2. JFS – Determination of Financial Eligibility
     - Financial requirements require a 5 year look back period

  ❖ Enrollment on the Assisted Living Waiver will never be backdated any sooner than the date of the Level of Care Assessment

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Tips for a positive partnership

- Build positive and open relationships with case managers
- Ensure the case manager has the most up to date name and contact information for relevant AL staff members (Director, DON, Billing)
- Case Managers reach out to the facility before coming out; try and be available for a brief discussion on an individual's care before or after the case manager visit.
- Share nursing and medication lists
- Communicate regularly

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Communication with Case Managers

When to communicate with the Case Managers

- Hospice enrollment
- Hospitalization (admissions, discharge dates, location, and diagnoses)
- Death
- Elopement (individual wandering out of the facility)
- Significant change in condition (outpatient surgery, increased level of care, wandering, behavior changes)
- Fall with injury
- Involvement with Physical Therapy, Occupational Therapy, Speech Therapy, or Skilled Nursing
- Individual is out of the facility (overnight stay, visiting family)

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What you can expect from Case Managers

- Case managers are required to complete in person visits/assessments with the individual or a legal representative a minimum of every 90 days
- Case managers are responsible for maintaining the service plan and care plan to meet ODA guidelines and sharing the person-centered service plans with the individual and AL staff
- Case managers are mandated reporters and will make reports to the Ohio Department of Health and The Long term Care Ombudsman as applicable
- Case managers are required to obtain annual signed paperwork required from individual/legal representative and facility
- Case managers will coordinate with those involved in the care of the individual (AL staff, CTS coordinator, medical staff, behavior health staff, families, legal representatives)
- Case managers will assist with obtaining needed DME and supplies

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Ohio Department of Aging Rules

- **OAC 173-39-02 Provider Certification:** Requirements for Providers to Become and to Remain Certified
  - Policies and Procedures
  - Insurances
  - Incident Reporting Requirements
- **OAC 173-39-02.17 Community Transition**
  - Guidelines and timeframes
  - Pays for non-recurring start-up living expenses for individuals transitioning from an institutional setting to a home and community-based services (HCBS) setting
  - See OAC 3701-16-15 Rule 3701-16-15 | Building Maintenance, Equipment and Supplies
- **OAC 173-39-02.16 Assisted Living Service**
  - Includes specific requirements for orientation that must be completed prior to direct care employees start of services
  - Includes specific requirements for basic service, memory care service, and critical access

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Assisted Living/Basic Care Service

- **OAC 173-39-02.16 (C)(5) Initial staff qualifications: Only a staff member who successfully completes training in the following subject areas qualifies to provide this service:**
  - Principles and philosophy of assisted living.
  - The aging process.
  - Cuing, prompting, and other means of effective communication.
  - Common behaviors for cognitively-impaired individuals, behaviorally-impaired individuals, or other individuals and strategies to redirect or de-escalate those behaviors.
  - Confidentiality.
  - The person-centered planning process in rule 5160-44-02 of the Administrative Code, which includes supporting individuals' full access to the greater community.
  - The individual's right to assume responsibility for decisions related to the individual's care.

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Assisted Living Waiver/Memory Care Service

- **OAC 173-39-02.16 (D)(4) Initial staff qualifications: A staff member qualifies to provide memory care without in-person supervision only if the staff member successfully completes training all of the following topics in addition to the topics listed under paragraph (C)(5) of this rule:**
- Overview of dementia: symptoms, treatment approaches, and progression.
- Foundations of effective communication in dementia care.
- Common behavior challenges specific to dementia and recommended behavior management techniques.
- Current best practices in dementia care.
- Missing resident prevention and response.

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Memory Care Service

- **Requirements for an ODA-certified provider of the basic service and memory care:**
- Did the provider meet all qualifications for basic service?
- Purpose statement on website?
- Where will the facility provide memory care service?
- Does the facility provide at least three therapeutic, social, or recreational activities per day with consideration given to individuals' preferences and designed to meet individuals' needs?
- Is there safe access to outdoor space?
- Call light compliance-fewer than 10 minutes?
- Is there a sufficient number of RNs and LPNs on site or on call at all times?
- Increased staff for memory care service-if also providing basic service, is the staffing 20% more on memory care around the clock?
- Have the personnel been trained on the five additional components of orientation?
- Dementia Training Completed per OAC 3701-16-06?

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Ohio Department of Health Rules

- **OAC 3701-13 Hiring of Direct-Care Provider Employees**
- **OAC 3721- specifically 3721.121-Criminal records check**
- RCFs are required to verify all BCIs under code 3721.121
- **OAC 3701-16 Residential Care Facility**
  - Note various ODH rules referred to in the Assisted Living Service rule including 3701-16-08 and 3701-16-06

Ohio Department of Health

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Ohio Department of Medicaid Rules

- **OAC 5160-44-01 Nursing facility-based level of care home and community-based services programs:** home and community-based settings
- **OAC 5160-44-02 Nursing facility-based level of care home and community-based services programs:** person-centered planning

Department of Medicaid

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Individual Rights and HCBS Settings Requirements

- The HCBS Settings Final Rule does two things
  1. Outlines the **federal rights** for individuals living in an assisted living setting or receiving adult day services and;
  2. Requires providers to **deliver services** in a way that doesn't violate those rights.

  - Providers must ensure the rights of every individual are upheld and protected through their facility policies and procedures, staff trainings, and by communicating regularly with PASSPORT Administrative Agency (PAA) case managers.

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Resident Rights

- **Individuals have the right to:**
  - Have a Lease or Resident Agreement
  - Privacy
  - Furnish and Decorate
  - Control Schedules and Activities
  - Have Access to Food at Any Time
  - Have Visitors at Any Time
  - Physically Access the Setting

  - Facilities are required to adhere to the rules regarding Home and Community Based Settings and to train their staff accordingly

- For more information, please visit The Ohio Department of Aging website at aging.ohio.gov, subscribe to updates and review training and provider memos.
- https://aging.ohio.gov/agencies-and-service-providers/training/hcbs-trainings
- https://aging.ohio.gov/see-news-and-events/Provider+Memos/provider-memo-oct-09-2024

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Common Deficiencies found during a Precertification Review/Annual Structural Compliance Review

- Orientation
- Incident Reporting
- Missing/Incorrect Quarterly Assessments
- Failure to Provide Nurse License Verification Prior to Hire
- BCI issues-Not using the correct code

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MyCare Ohio Overview

- Established in 2014 as a demonstration project
- Capitated model under CMS' Financial Alignment Initiative
- Ending December 31, 2025
- **Current Status (as of April 2024)**
  - Serves over 62,000 Ohioans
  - 29 out of 88 counties in Ohio participate
  - Consumers have a choice of two Managed Care Organizations (MCOs) in each PAA region
  - Assignment to an MCO if no choice is made
  - If eligible, must transition to a MyCare Program if offered in the county consumer lives in.

MyCareOhio
Connecting Medicare + Medicaid

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MyCare Eligible Criteria

- Age 18 or older
- Reside in one of the 29 demonstration counties
- Receive full Medicaid services and Medicare Parts A, B, and D
- **Comprehensive Coverage**
  - All benefits from traditional Medicare and Medicaid
  - Long-term care services (if applicable)
  - Behavioral health services
  - Additional benefits may vary by MyCare Plan
  - Single point of contact
  - Person-centered care
  - Minimal difference in experience compared to Traditional Assisted Living

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MyCare Consumer Experience

- **Differences Between Assisted Living Waiver and MyCare AL**
  - Assisted Living is its own waiver; MyCare includes Assisted Living as a service
  - Coverage may vary among MyCare MCOs
  - Visit schedules may differ
  - Potential additional benefits from MyCare MCOs
- **Billing Differences**
  - Traditional AL Waiver billed through COAAA; CMs have more ability to assist
  - MyCare AL must work through MCOs; CMs have less ability to assist

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Transition to Next Generation MyCare Ohio

- Transitioning to FIDE-SNP model in January 2026
- CMS is sunsetting the demonstration project
- **What is FIDE-SNP?**
  - Fully Integrated Dual Eligible Special Needs Plan
  - Combines Medicare and Medicaid benefits into one health plan
  - Related to MyCare as a Medicare-Medicaid Plan (MMP). FIDE SNP most closely related as compared to other D-SNPs.
- D-SNPs are a type a type of Medicare Advantage managed care plan that only enroll dually eligible individuals.
- All D-SNPS hold contracts with state Medicaid agencies in states where they operate

D-SNP does not bear Medicaid risk*

D-SNP bears Medicaid risk

CO-D-SNP	HIDE-SNP	FIDE-SNP
• Organization must notify state or designee when a defined subset of full duals are admitted to a hospital or skilled nursing facility (SNF), using a process defined by the state	• Parent organization has a contract for capitated Medicaid Long-Term Services and Supports (LTSS) and/or Behavioral health (BH) in the state • May include non-comprehensive Medicaid contracts (e.g., prepaid inpatient health plans)	• Parent organization has a contract inclusive of Medicaid LTSS and BH consistent with state policy and is under the same legal entity as the D-SNP • Must include 180 nursing facility days per year

*D-SNP might bear Medicaid risk for physical health, but integration risk-bearing requirements are based on LTSS and BH risk.

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MMPs versus D-SNPs

Differences Between MMPs and D-SNPs

Feature	Medicare-Medicaid Plans	Dual Eligible Special Needs Plans
Plan Structure and Contract	• Single-plan model (Medicare-Medicaid Plan (MMP)) • 3-way contract among CMS, the state, and the plan	• Two-plan model: Aligned D-SNP and Medicaid managed care plan operated by the same parent entity • Separate contracts between the D-SNP and the state, and the D-SNP and CMS
Enrollment	• Mix of voluntary enrollment and passive enrollment with opt-out	• Voluntary enrollment • Potential for default enrollment if approved by the state and CMS
Care Coordination	• Three-way contracts tell the MMPs what their care coordination requirements are and how they must meet those requirements	• State Medicaid Agency Contract (SMAC) and the Model of Care (MOC) guide areas of focus for D-SNP care coordination, but the D-SNPs tell CMS what they will do, as well as how they will accomplish those things
Oversight and Monitoring	• Joint state and CMS Contract Management Team (CMT) meets regularly to oversee of MMPs, including development of quality measures and requesting reporting performance and quality data at plan level	• Separate Medicare and Medicaid oversight processes and quality measure/tools • Separate oversight of CMS SMAC requirements and state SMAC requirements

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Current Updates for MyCare Next Generation

- ODM in RFP process to select MCOs
- Expectation of 4 MCOs managing consumers statewide
- Transition for 29 MyCare counties to FIDE SNP
- Non-MyCare counties transitioning at later dates

- **Future of MyCare Ohio**
  - MCOs must contract with both CMS and ODM
  - Additional requirements anticipated to enhance integration for enrollees

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Questions

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