Ohio Administrative Code

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

Effective: January 1, 2026

(A) The general definitions set forth in rule 5160-26-01 of the Administrative Code regarding managed care entities (MCEs) apply to the MyCare Ohio rules set forth in Chapter 5160-58 of the Administrative Code.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, 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) "Auto-assign" means the process for determining in which MyCare Ohio Plan (MCOP) a member is assigned. Auto-assignment uses preset rules to best match needs and preserve existing provider-patient relationships. The process does not include manual intervention for assignment.

(3) "Care management" means a collaborative, team based, and personalized approach that encompasses the full spectrum of care coordination activities, ranging from short term assistance to meet care gaps to long term, intensive and holistic care coordination for members with the most intensive needs, designed to assist members and their support systems in managing medical conditions and social determinants of health (SDOH) more effectively. Care management includes care coordination activities to deliberately organize and support an individual to address needs for the purpose of achieving better health outcomes.

(4) "Care coordinator" means a healthcare professional who works with individuals to create and manage their care plans. Care coordinators help individuals navigate the healthcare system, access resources, and advocate for the individuals'needs. They assess individuals' physical, psychological, and social needs, develop personalized care plans, coordinate care, monitor individuals' progress, provide education, connect individuals with community resources and other support services, and

address individuals' social determinants of health.

(5) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (January 1, 2026).

(6) "Critical incident" is defined in rule 5160-44-05 of the Administrative Code.

(7) "Dual benefits member" means an individual for whom a MyCare Ohio plan is responsible for the coordination and payment of both medicare and medicaid benefits.

(8) "Dual-eligible member" means an individual who is eligible for and enrolled in medicare parts a, b, and d, and full benefits under the medicaid program as defined in paragraph (B)(11) of this rule.

(9) "Dual special needs plan (D-SNP)" is defined in 42 CFR 422.2 (October 1, 2025).

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

(11) "Full benefits under the medicaid program" means the full scope of services covered by the medicaid state plan. Medicaid-enrolled individuals who have full benefits under the medicaid program exclude individuals whose medicaid enrollment is categorized as:

(a) Presumptive eligibility under rule 5160:1-2-13 of the Administrative Code;

(b) Non-citizen emergency medical assistance under rule 5160:1-5-06 of the Administrative Code;

(c) Refugee medical assistance under rule 5160:1-5-05 of the Administrative Code;

(d) Medicare premium assistance program under rule 5160:1-3-02.1 of the Administrative Code;

(e) Inmates subject to restrictions on medicaid payment under rule 5160:1-1-03 of the Administrative Code.

(12) "Fully integrated dual-eligible special needs plan (FIDE SNP)" is defined in 42 CFR 422.2 (October 1, 2025).

(13) "Health and welfare" as described in 42 CFR 441.302 (October 1, 2025) refers to a federal requirement that necessary safeguards are taken to protect the safety and independence of individuals enrolled in a home and community-based services (HCBS) waiver. Examples of such safeguards includes, without limitation:

(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.

(14) "Home and community-based services (HCBS)" means services available to individuals to help maintain their health and safety in a community setting in lieu of institutional care as described in 42 CFR 440 subpart A (October 1, 2025).

(15) "Hybrid services" are services which are covered by both medicare and medicaid.

(16) "Individual" is defined in rule 5160-1-04 of the Administrative Code.

(17) "Individual care plan" means an integrated, individualized, person-centered care plan developed

by the individual and his or her MyCare Ohio plan's inter-disciplinary care management team that addresses clinical and non-clinical needs identified in the assessment and includes goals, interventions, and expected outcomes.

(18) "Interdisciplinary care management team" means a team made up of the member, the individual's authorized representative, the member's managed care team, other professionals, and information supports chosen by the member. The MCOP provides the member's care coordinator, and waiver service coordinator if the member is enrolled on the MyCare Ohio HCBS waiver, and internal support staff, such as social workers, mental health and substance use disorder licensed independent professionals, gerontologists, housing specialists, transportation specialists, and community health workers, to support the care coordinator.

(19) "Medicaid-only member" means an individual for whom a MyCare Ohio plan is responsible for coordination and payment of medicaid benefits, and, upon request, is responsible to assist with coordination of medicare benefits.

(20) "Member" is defined in rule 5160-26-01 of the Administrative Code.

(21) "MyCare Ohio plan (MCOP)" means a health insuring corporation (HIC), as defined in section 1751 of the Revised Code, which is also a FIDE SNP, contracted to comprehensively manage medicaid benefits, including HCBS, for medicare and medicaid eligible members. An MCOP is also a managed care organization as defined in rule 5160-26-01 of the Administrative Code. For the purpose of this chapter, an MCOP does not include entities approved to operate as a program for the all-inclusive care of the elderly (PACE) site as defined in rule 5160-36-01 of the Administrative Code.

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

(23) "Person-centered services plan" is defined in rule 5160-44-02 of the Administrative Code.

(24) "Self-direction" means a service model that empowers individuals with choice and control over identifying, accessing, and managing the long-term services and supports needed to live at home

while considering their personal preferences. Self-direction includes both self-directed services in accordance with rule 5160-45-03.2 of the Administrative Code and participant direction under rule 173-42-06 of the Administrative Code.

(25) "Significant change event" is a change experienced by a individual that warrants further evaluation. Significant changes include, but are not limited to, a change in health status, caregiver status, location, or 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.

(26) "Waiver services plan" is a component of the person-centered care plan that identifies specific goals, objectives, and measurable outcomes for a waiver-enrolled individual'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 includes:

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

(b) Signatures indicating the individual's acceptance or rejection of the waiver services plan. If the member is unable to provide the signature when the services plan is initially developed, the individual submits an electronic signature or standard signature via regular mail, or otherwise provide a signature in no instance any later than at the next face-to-face visit with the care coordinator; and

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