Is it a requirement to always use state plan home health services before authorizing the waiver service?

The use of the clinical decision making process is a tool to assist the case manager in determining the most appropriate service and funding source to meet the waiver participant's assessed needs.

- The waiver personal care service and the Medicaid home health service are not interchangeable. Although the services have some tasks in common, the two services are authorized for different purposes

- The Medicaid home health service should be accessed when this is the most appropriate service to meet the consumer's assessed unmet need(s)

- There is no requirement for the 14 hours of Medicaid home health aide service to be accessed for every waiver participant before any personal care waiver services are authorized.

- The maximum Medicaid home health aide service benefit should be utilized when this service is determined to be the most appropriate service to meet the waiver participant's assessed need(s).

Define "consumer choice"

Consumer Choice: In the context of an HCBS waiver, consumer choice begins with the eligible individual's decision to choose HCBS waiver services rather than institutional services. Upon enrollment and ongoing, the waiver participant's service planning and service implementation choices include: (a) choice of waiver services that provide the interventions to meet assessed needs (b) choice of willing and qualified providers of the identified waiver service; (c) the choice to change providers; and (d) the choice to decline services from the first funding source; and (d) the right to assume risk when declining services/interventions to meet assessed needs.

How do the practice guidelines apply to new consumers?

At the time of the initial assessment, the decision making process will be used to identify the most appropriate service(s) and funding sources required to meet the assessed needs of the waiver participant. Waiver services are authorized only when the case manager has determined no other services, furnished by alternate funding sources, can meet the assessed unmet needs of the waiver participant.

How do the practice guidelines apply to existing consumers?

At the next face to face contact with the waiver participant, the case manager should review the service plan to determine the assessed unmet needs of the waiver participant currently being met by a waiver service can not be furnished by an alternate funding source.

- The most logical points of contact include: quarterly visits, annual re-assessment, event-based re-assessment, or request for service increase.

- Hearing rights are issued when an existing waiver service authorization is reduced as a result of the initiation of Medicaid home health services.

How do the practice guidelines apply to consumers who choose the PASSPORT consumer-directed personal care service or enrollment in the Choices waiver?

The Medicaid home health service should be accessed when this is the most appropriate service to meet the consumer's assessed unmet need(s). The use of the clinical decision making process is the practice norm to be used in all ODA-administered waivers.