CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Home and community-based services waiver alignment: Phase 1 – Home Delivered Meals and Personal Emergency Response Systems (PERS)

Rule Number(s): 5160-44-11, 5160-44-16, and 5160-31-07

Rules 5160-01-06.1 and 5160-46-06 are not subject to CSIO review but is included for reference.

Date: September 10, 2018

Rule Type:

- [X] New
- [X] Amended
- [ ] 5-Year Review
- [ ] Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Both the Ohio Department of Medicaid (ODM) and the Ohio Department of Aging (ODA) administer home and community-based services (HCBS) nursing facility level of care waivers.

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ODM-administered HCBS waivers include the MyCare Ohio and Ohio Home Care waivers. ODA-administered HCBS waivers include the preadmission screening system providing options and resources today (PASSPORT) and Assisted Living waivers. Each waiver is described under its own chapter of the OAC and while services across waivers may be similar, they are not uniform.

It is not uncommon for individuals receiving services through these waivers to move from one waiver to another depending on criteria such as age, Medicare eligibility, service needs and/or county of residence. Also, often providers deliver services to individuals across all waivers, but are made to adhere to different standards depending on the waiver enrollment of the individual they are serving. This causes confusion among individuals and providers alike and results in a lack of continuity of care.

To bring consistency to the ODM and ODA administered waiver programs to benefit individuals and providers, the two agencies have been collaborating to align the OAC rules governing the various waiver programs. This rule package reflects phase one of the HCBS waiver alignment collaboration and includes service and rate alignment efforts.

The adoption of a consistent rate methodology and maximum allowable rates paid for the same service in Ohio Home Care and PASSPORT waiver programs results in the elimination of the unexplained variability in rates for the same service, complies with the Centers for Medicare and Medicaid Services (CMS) requirement for rate methodologies to be established for services furnished in 1915(c) waivers, and invests additional resources in home and community-based services (HCBS). This policy does not change the MyCare Ohio transition of care requirements. The MyCare Ohio plans will continue to negotiate individual contracts with HCBS providers. If a MyCare Ohio plan chooses to use the fee-for-service rate as a basis for establishing rates with contracted providers, the provider's contracted rate could be impacted.

5160-31-07 "PASSPORT HCBS waiver program rate setting" is being proposed for amendment to update policy and to align ODA and ODM rates for certain HCBS. This rule sets forth the rate setting methodology for the PASSPORT HCBS program.

5160-44-11 "Nursing facility-based level of care home and community-based services programs: home delivered meals" is being proposed as new to implement home delivered meal services in Chapter 5160-44 of the Administrative Code. This rule sets forth the definitions, service description, meal specifications (menu and delivery), limitations and provider qualifications. It replaces language currently set forth in Rule 5160-46-04 of the Administrative Code.

5160-44-16 "Nursing facility-based level of care home and community-based services programs: personal emergency response systems" is being proposed as new to implement personal emergency response systems (PERS) in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, equipment specifications, PERS limitations, and PERS provider requirements. It replaces language currently set forth in Rule 5160-46-04 of the Administrative Code.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code Section 5166.02.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?** ***If yes, please briefly explain the source and substance of the federal requirement.***

   Yes, for the Centers for Medicare and Medicaid Services (CMS) to approve a 1915(c) home and community-based services (HCBS) waiver, a state must meet certain assurances about the operation of the waiver. These assurances are spelled out in 42 C.F.R. 441.302, and include:

   > *(a) "Health and Welfare -Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. Those safeguards must include—*
   > *(1)Adequate standards for all types of providers that provide services under the waiver;*
   > *(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver;"*

   Providers of HCBS waiver services must be qualified, i.e., only those agencies and persons who meet the state's qualification requirements can provide services to waiver participants. The proposed rules will assist the State in assuring the health and welfare of waiver participants by establishing specific qualifications and requirements providers must meet to render waiver services.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules are consistent with federal requirements. They define specific processes for meeting HCBS waiver program provider eligibility requirements as required by CMS.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of these regulations is to assure the health and welfare of individuals enrolled in an ODM or ODA-administered HCBS waiver as required by 42 C.F.R. 44 I. 302(a) through the provision of services by qualified providers. The State is doing so by establishing requirements that providers must meet to be HCBS waiver service providers.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   Successful outcomes are measured through a finding of compliance with provider standards. The expectation is that adherence to the provider requirements will result in a reduced number of

incidents that threaten the health and welfare of individuals participating in the waiver program. This is evidenced, in part, by no adverse findings resulting from structural reviews and investigation of alleged provider occurrences.

Development of the Regulation

7. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

ODM has been convening the HCBS Rules Workgroup since May 2013, to draft and review OAC rules governing ODM-administered waivers. This stakeholder group generally meets monthly (in-person and by phone) and plays a critical role in the ODM and ODA HCBS waiver alignment initiative. OAC rules 5160-44-11 and 5160-44-16 were drafted and shared with providers initially in 2017 for review and comment. Draft OAC rule 5160-31-07 was shared with stakeholders on August 16th via email allowing a week for public comment. The HCBS Rules Workgroup email group includes over 900 members. The workgroup consists of individuals enrolled on ODM-administered waivers, independent providers and organizations.

The rules in this rule package are specific to home delivered meals and personal emergency response systems (PERS). In addition to the HCBS Rules Workgroup participants, and Medicaid managed care plans, the service providers listed below were active in the rule drafting and stakeholder processes.

Home Delivered Meals

Benjamin Rose Institute
Beyond Eating, LLC.
Community Caregivers of the Valley
Clermont Senior Services
Geurnsey Senior Services
Home Care with Heart
Homes Meals
Homestyle Direct
Lifecare Alliance
Meals on Wheels of Stark and Wayne Counties
Mobile Meals
Mom's Meals
Ohio Academy of Nutrition and Dietetics
Ohio Council for Home Care and Hospice
Ohio Department of Health
Person-Centered Services
Sellers-Dorsey Consultants
Simply EZ (home delivered meals)

Personal Emergency Response Services
ADT
Benjamin Rose Institute – Cleveland
Blackstone
Caregiver Homes
CareSource
CareStar
Colwell Group/Safe In Home
Guardian Medical Monitoring
HealthCom Inc.
Ideal Life
Leading Age Ohio
Ohio Council for Homecare and Hospice
Ohio Long Term Care Ombudsman
Phillips Lifeline

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

Stakeholders are of critical importance in identifying the service specifications and provider requirements for each of the HCBS waiver services. Throughout the HCBS waiver alignment initiative, stakeholders have provided a tremendous amount of feedback related to the rule drafts. Often the suggested edits are incorporated, and updated drafts are vetted.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

No scientific data was used to develop the rules or the measurable outcome of the rules.

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

Both ODM and ODA policies were considered by the interagency HCBS waiver alignment team. However, the language must meet the federal and state guidelines under which both ODM and ODA-administered waivers are permitted to operate.

11. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

No. Performance-based regulations are not deemed appropriate and are not authorized by statute.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

All regulations regarding the ODM and ODA HCBS waiver programs are promulgated by ODM and ODA and implemented by ODM and ODA, its designees and providers, as appropriate. The regulations are reviewed by the interagency legal and legislative staff to ensure there is no duplication within the rules. The HCBS waiver alignment initiative will further ensure the regulation on these providers is not duplicative.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

A robust effort will be employed by ODM and ODA to notify HCBS waiver participants and service providers of plans regarding aligned OAC rules. Initial notification of the rules will occur via a variety of communication methods including ODM's issuance of emails to agency and independent providers and electronic communication the provider oversight contractor's (PCG) website.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

Currently, there are approximately 106 home delivered meals providers and approximately 83 personal emergency response systems providers in the state. Many of these providers render services across waivers and will benefit from an aligned policy.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

OAC rule 5160-31-07 requires Ohio Department of Aging (ODA) or their designee to hold a provider agreement with providers of home and community-based services (HCBS).

OAC rule 5160-44-11 requires providers of home delivered meals to obtain a food operations license or other applicable license or certificate. Providers must develop, implement and maintain evidence of a training plan for staff that includes orientation and annual continuing education. Administrative costs may be incurred due to the requirement that delivery instructions are provided to the delivery driver and when notification must be made to individuals that the meal will be delayed. Lastly, providers must maintain documentation of meal delivery, clinical records and employee training and licensure information.

OAC rule 5160-44-16 requires providers to maintain documentation related to the individual and services provided which may result in administrative costs.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

ODM reached out to several providers of home delivered meals and personal emergency response systems (PERS) to determine costs associated with the requirements of the rules. Several responses are listed below, however, some providers included a comprehensive listing of costs associated with business practices which are not required by the rules in this BIA.

Maintaining Certification
LifeCare Alliance informed ODM that there is no cost associated with obtaining and maintaining ODA-certification and contracting with ODA's designee.

VRI, a provider of personal emergency response systems (PERS) informed ODM that the cost of maintaining certification with ODA is de minimus on a per client basis. It is a fixed cost and doesn't change with volume and is very small on a per client basis (less than 1 cent per client).

Schmidt Security Pro, also a provider of PERS services, responded that the annual cost of obtaining and maintaining ODA-certification and the contract with ODA's designee is approximately $380 total.

Simply EZ, a home delivered meal provider, responded that the cost of maintaining certification and a contract is approximately $4,000. This includes overhead for administrative activities and staff attendance in meetings.

Licensure Requirements
According to LifeCare Alliance, the average cost of obtaining a food operations license or other applicable license or certificate as required by licensing or regulatory agencies where the meal is produced is as follows:

- Food Service License (Ohio Department of Health) - $290
- Meat Inspection (Ohio Department of Agriculture, Meat Inspection) - $100
- Frozen Food (Ohio Department of Agriculture, Food Safety) - $100
- Kosher (VAAD) - $850

Additionally, LifeCare Alliance has ODAgr staff onsite eight hours a day, and the Agency pays on average $3,000 per year in overtime to cover the salary of this staff person.

Simply EZ included the following costs in their estimate of expenditures:

- One-time payment for vendor license - $250
- ServSafe certification for management every 5 years - $900
- Annual dietitian license - $500

Mobile Meals of Toledo, Inc. responded that the costs for food operations licenses, including costs for trucks is a total of $1,863 per year.

Clossman Catering responded that the cost for license fees (Health Department, Department of Agriculture, etc.) is $1,000 annually.

Staff Training and Development

LifeCare Alliance incurs costs of developing, implementing and maintaining evidence of a training plan that includes orientation and annual continuing education. Regarding ongoing training of staff, there is an approximate annual ongoing cost of $7,000 total to the Agency (69 drivers receiving 1.5 hours of training 4 times a year at an average of $10 per hour PLUS the same for driver and kitchen supervisors).

Simply EZ informed ODM that costs of developing, implementing and maintaining evidence of a training plan includes the following costs:

- $3,300 annually for four hours continuing education, outside instructor fees, research, educational materials, make-up days for absent employees.
- $800 for maintaining documentation of the training.

Mobile Meals of Toledo, Inc. provided estimates of $2,000 annually for new employee orientation and training (this cost includes fingerprinting which is not required by this rule), and $3,115 annually for continuing education credits.

Delivery Instructions and Delay Notification

LifeCare Alliance incurs administrative costs associated with providing delivery instructions to the delivery driver and/or notifying an individual if the meal will be delayed. In general, to route a consumer and to put some delivery basics in for a consumer it takes about five minutes for LifeCare Alliance. This works out to about $1.20 per new client and about .40 per client per year for routing maintenance. Additionally, considering the amount of paper that it takes up to provide delivery instructions on the hard copy volunteer delivery records, there is certainly a paper cost. The door to door instructions provided on the delivery records probably increases the number of pages printed by 15%. About 250 sheets are used each day Monday-Friday for 500 front and back pages of delivery records, and we use about 85 sheets per Saturday and Sunday of 170 front and back pages of delivery records. Between paper and toner, printing delivery records costs about $5 per weekday and $2 per weekend day. If the delivery instructions were removed from the volunteer records, this would save the Agency about .75 per weekday, and drilling down further, about 10% of our consumers are PASSPORT, MyCare or Waiver appearing on volunteer routes. Therefore, per client the printed delivery instructions cost the Agency about .10 per client per year. In summary, per PASSPORT, MyCare, and Waiver consumer, there is a one-time expense of $1.20 for routing the consumer, an annual .40 per client per year routing maintenance expense, and .10 per year for printed delivery instructions.

Simply EZ incurs administrative costs associated with providing delivery instructions to the delivery driver and/or notifying an individual if the meal will be delayed. These costs include $200 to contact all consumers on a route that is delayed, calls come from office (+/- 3 per week).

Mobile Meals of Toledo, Inc. responded that they incur administrative costs associated with providing delivery instructions in the amount of $5,100 and delay notifications of $500 annually.

Maintaining Documentation

LifeCare Alliance incurs administrative costs associated with maintaining documentation of meal delivery, clinical records for individuals served and with maintaining documentation of employee training or agency licensure. Since LifeCare Alliance started storing the care plans and HIPAA/release signature pages electronically, the cost of file folders and filing time has essentially been removed. Reviewing the delivery records for signatures takes about two hours total per day - $24 per day. Organizing the delivery records monthly for storage is about two hours of work - $26 per month. LifeCare Alliance has a monthly $300 expense for maintaining our hard copy records in fireproof storage. Accounting for only the 17% of PASSPORT, MyCare, and Waiver consumers, it costs about $56 per month for managing the delivery records for these funding sources – or .13 per consumer per month.

Simply EZ incurs administrative costs associated with maintaining documentation of meal delivery, clinical records for individuals served including:

- $350 per week to create route logs, highlight any driver notes, update notes in database for bi-weekly consumers, or holds;
- $250 per week to sign off on route logs as drivers return, update any notes from route logs into database, filing route logs;
- $75 discuss then document food items consumer cannot eat from two-month rotating menu, find nutritionally equivalent substitutions, create new food list for kitchen staff; and
- $260 monthly for an outside storage facility to keep files on employees and consumers for 7 years.

Mobile Meals of Toledo, Inc. incurs administrative costs associated with maintaining documentation in the amount of $18,705 for meal delivery records and $500 for employee records.

VRI informed ODM that the costs of maintaining documentation is difficult to calculate on a per client basis, but it is relatively low. VRI estimates the cost of maintaining documentation to be less than 10 cents per client per month.

Schmidt Security Pro gathered info from employees on the time spent on various activities involved in maintaining documentation and arrived at an estimated annual cost to the company of $35,080. This is based upon an average of 800 individuals to whom

services are rendered at any one time under Medicaid-sponsored agencies, which would average about $44 per year per client.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The assurance of HCBS waiver participants' health and welfare is integral to the Ohio HCBS waiver programs – both at the state and federal levels. Provider participation in this waiver is optional and at the provider's discretion. Compliance with program requirements is required for providers who choose to participate and may result in administrative costs associated with compliance with the requirements of these rules (e.g., training, monitoring and oversight, etc.). Failure to comply with such requirements may result in a provider's inability to be an Ohio HCBS waiver service provider.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No, not applicable for this program.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Not applicable for this program.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers may contact the Ohio Department of Medicaid (ODM) provider hotline at 1-800-686-1516.

5160-1-06.1 **Home and community-based service waivers: PASSPORT.**

(A) The Ohio department of aging (ODA) is responsible for the daily administration of the preadmission screening system providing options and resources today (PASSPORT) medicaid waiver program. ODA ~~will~~ shall administer the waiver pursuant to an interagency agreement with the Ohio department of medicaid in accordance with section 5162.35 of the Revised Code.

(B) The PASSPORT waiver provides home and community based services to ~~persons aged sixty and over that require an intermediate or skilled care level of care as set forth in rule 5160-3-08 of the Administrative Code and are enrolled in the waiver.~~individuals enrolled in the waiver in accordance with rule 5160-31-04 of the Administrative Code.

(C) The PASSPORT HCBS waiver covered services and ~~program~~ eligibility ~~criteria~~ requirements are set forth in Chapter 5160-31 of the Administrative Code.

(D) The maximum allowable ~~reimbursement~~payment rates for PASSPORT HCBS waiver program services are listed in appendix A to this rule.

(E) PASSPORT HCBS ~~reimbursement~~payment must be provided in accordance with paragraphs (A) to (C) of rule 5160-1-60 of the Administrative Code.

(F) ~~An individual may not receive community transition services with a cumulative or singular value in excess of one thousand four hundred seventy-seven dollars and fifty cents. The individual may only access the goods and services available through the community transition service as set forth in rule 173-39-02.17 of the Administrative Code.~~

Effective:

Five Year Review (FYR) Dates:

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	173.52
Prior Effective Dates:	01/01/2004, 07/01/2006, 07/02/2007 (Emer.), 10/01/2007, 07/01/2008 (Emer.), 09/30/2008, 07/01/2011 (Emer.), 09/29/2011, 07/01/2013 (Emer.), 09/27/2013, 03/01/2014, 07/01/2014, 01/01/2017

AMENDED
Appendix
5160-1-06.1

PASSPORT WAIVER RATES

WAIVER	UNIT	BILLING MAXIMUM
Adult Day: enhanced	1 day	$49.39
Adult Day: enhanced	½ day	$24.70
Adult Day: enhanced	15 minutes	$1.55
Adult Day: intensive	1 day	$64.84
Adult Day: intensive	½ day	$32.41
Adult Day: intensive	15 minutes	$2.03
Adult Day Transportation	1 mile	$2.22
Adult Day Transportation	Round Trip	$20.40
Adult Day Transportation	1 one-way Trip	$16.55
Alternative Meals	1 meal	$31.35
Choices Home Care Attendant	15 minutes	$6.25
Chore	1 job	$2,612.47
Community Transition	1 completed job or deposit	$1,477.50
Enhanced Community Living	15 minutes	$5.06
Home Care Attendant	Unit is established in OAC 5160-46-06.1	Reimbursement is established in OAC 5160-46-06
Home Delivered Meals : regular	1 meal	$6.50
Home Delivered Meals : therapeutic and kosher	1 meal	$8.68
Home Medical Equipment and Supplies : Ambulatory	1 item	$5,224.93
Home Medical Equipment and Supplies : 2nd Ambulatory	1 item	$5,224.93
Home Medical Equipment and Supplies : 3rd Ambulatory	1 item	$5,224.93
Home Medical Equipment and Supplies : Non-ambulatory	1 item	$5,224.93
Home Medical Equipment and Supplies : 2nd Non-ambulatory	1 item	$5,224.93

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Home Medical Equipment and Supplies : 3rd Non-ambulatory	1 item	$5,224.93
Home Medical Equipment and Supplies : Hygiene and Disposables	1 item	$5,224.93
Home Medical Equipment and Supplies -Hygiene and Disposables: 2nd Hygiene and Disposables	1 item	$5,224.93
Home Medical Equipment and Supplies -Hygiene and Disposables: 3rd Hygiene and Disposables	1 item	$5,224.93
Home Medical Equipment and Supplies : Equipment Repair	1 item	$5,224.93
Home Medical Equipment and Supplies : Nutrition Supplement and Supplies	1 item	$5,224.93
Independent Living Assistance : In-Person Activities	15 minutes	$5.22
Independent Living Assistance : Travel Attendant	15 minutes	$5.22
Independent Living Assistance : Telephone Activities	1 completed call	$5.22
Minor Home Modification, Maintenance and Repair	1 completed job	$10,000
Non-emergency Transportation	1 round trip	$1,306.24
Non-emergency medical Transportation	1 round trip	$653.11
Non-medical Transportation	1 round trip	$1,306.24
Non-medical Transportation	1 one-way trip	$653.11
Nutritional Consultation	15 minutes	$13.34
Out of Home Respite	Unit is established in OAC 5160-46-06	Reimbursement is established in OAC 5160-46-06.
Personal Care: agency	15 minutes	$4.49
Personal Care: participant-directed individual provider	15 minutes	$3.13

Personal Emergency Response System: installation	1 completed installation	$32.95
Personal Emergency Response System: ongoing	1 monthly rental	$32.95
Pest Control	1 completed job	$783.74
Social Work Counseling	15 minutes	$16.26
Waiver Nursing	Unit is established in OAC 5160-46-06.	Reimbursement is established in OAC 5160-46-06.1

5160-31-07 **PASSPORT HCBS waiver program rate setting.**

The purpose of this rule is to describe the methods used to determine provider rates ~~for the pre-admission screening system providing options and resources today (PASSPORT) home and community-based services (HCBS) medicaid waiver~~ for the PASSPORT program.

(A) Rates determined under this rule shall not exceed the maximum allowable ~~reimbursement~~ rates for PASSPORT services in appendix A to rule 5160-1-06.1 of the Administrative Code. Payment for PASSPORT ~~HCBS~~ waiver services constitutes payment in full and ~~may~~shall not be construed as a partial payment when the payment amount is less than the provider's usual and customary ~~charge~~rate.. The provider ~~may~~shall not bill the individual for any difference between the medicaid payment and the provider's ~~charge~~ rate or request the individual to share in the cost through a co-payment or other similar charge.

(B) PASSPORT ~~reimbursement~~ rates are established for the services in rule 5160-31-05 of the Administrative Code under the following categories:

(1) ~~Per job~~Per-job bid rate;

(2) ~~Per item~~Per-item rate; and

(3) Unit rate.

(C) Rates set within the categories in paragraph (B) of this rule may be:

(1) Participant-directed, in which the individual or ~~their~~ his/her designated authorized representative, who is acting on the individual's behalf, may negotiate the reimbursement rate for services furnished by providers as specified in paragraphs (D)(3), (E)(3), (G)(4), and (H) of this rule.

(2) Statewide, in which the state establishes a rate ~~that is~~ used on a statewide basis to reimburse for services specified in paragraph (F) of this rule.

(3) Regional, in which the state establishes a regional ~~reimbursement~~ rate for services specified in paragraph (G) of this rule. The regions in which applicable rates are calculated shall be designated by ODA.

(a) The regional rate for each service shall be the weighted average rate paid in the region using cost and unit data either from the most recently completed state fiscal year or the most recent twelve calendar months for which complete data is available, whichever is later.

(b) ODA or its designee shall enter into a ~~contract~~provider agreement with providers in each region. The ~~contract shall~~ provider agreement shall do all of the following:

(i) Specify the time period for which the rates shall be in effect;

(ii) Specify the timelines for contracting;

(iii) Define the region/subregions for which the rates will be established;

(iv) Base rates on the units of service as set forth in appendix A to rule 5160-1-06.1 of the Administrative Code;

(v) Reflect the agreed upon rate ~~the provider is willing to accept~~;~~-~~and

(vi) Adjust the regional rate up to the nearest number that is divisible by four, out to two decimal places.

(c) Regional ~~contract~~ provider rates shall be established as follows:

(i) No provider shall have a ~~contract~~ rate ~~that exceeds~~exceeding the ~~rate for that service~~maximum allowable rate for the service as established in Appendix A to rule 5160-1-06.1 of the Administrative Code.

(ii) If the state recalculates regional rates for the services in paragraph (G) of this rule, certified providers may either accept the new regional rate or continue to be ~~reimbursed~~paid at the rate paid for services prior to the calculation of the regional rate.

(iii) Providers ~~who are~~ certified after the regional rate is established shall have a ~~contract~~provider rate less than or equal to the regional rate.

(4) Group rates, ~~in which a provider that is furnishing certain services to more than one individual enrolled on PASSPORT is reimbursed at~~ are ~~a rate that is~~ seventy-five per cent of the reimbursement rate the provider would be paid for ~~furnishing~~ providing PASSPORT services as specified in paragraphs (D)(2), (F)(2), (G)(2), and (G)(3) of this rule.

(D) For the services listed in this paragraph, a ~~per job~~per-job bid rate shall be negotiated between the provider and the individual's case manager.

(1) A ~~per job~~per-job bid rate shall be used for the following services:

(a) Chore ~~services~~;

(b) Community transition ~~services~~;

(c) Minor-home modification, maintenance and repair ~~services~~;

(d) Non-medical transportation ~~services~~;

(e) Non-emergency medical transportation;

~~(e)~~(f) Pest control ~~services~~; and

~~(f)~~(g) ~~Transportation services~~.

(2) Non-emergency medical ~~Transportation~~transportation and non-medical transportation ~~services~~ rendered simultaneously by the same provider to more than one individual enrolled in PASSPORT residing in the same household and traveling in the same vehicle to the same destination shall be ~~reimbursed~~paid using ~~a~~ the group rate ~~-~~that is equal to seventy-five per cent of the provider's ~~per-job~~per-job bid rate. This shall ~~applies~~apply to any combination of non-emergency medical transportation and/or non-medical transportation services.

(3) Minor home modification maintenance and repair and pest control services may be participant -directed services in which the individual enrolled on PASSPORT or ~~their~~his/her authorized representative, acting on the individual's behalf, may negotiate reimbursement rates.

(a) The negotiated rate shall be reviewed by the individual's case manager and reflected on the individual's person-centered service plan prior to service delivery.

(b) Should the individual choose not to negotiate a rate of reimbursement the service shall be reimbursed at a rate proposed by the provider and accepted by the individual and the individual's case manager. The accepted rate shall be reflected on the individual's person-centered service plan.

(E) A ~~per item~~per-item rate shall be determined for home medical equipment and supplies service..

(1) The cost of the item shall not exceed the medicaid state plan rate.

(2) The cost of an item that does not have an established medicaid rate shall be ~~reimbursed~~paid at a ~~per item~~per-item bid rate submitted and agreed to in

writing by ~~the PASSPORT administrative agency (PAA)~~ODA's designee prior to delivery of the item.

(3) Home medical equipment and supplies services may be participant- directed in which the individual enrolled on PASSPORT or the authorized representative, acting on the individual's behalf, may negotiate reimbursement rates.

(a) The negotiated rate shall be reviewed by the individual's case manager and reflected on the individual's person-centered services plan prior to service delivery.

(b) Should the individual choose not to negotiate a rate ~~of reimbursement~~ the service shall be ~~reimbursed~~paid at a rate ~~proposed~~agreed upon ~~by the~~between the provider, ~~and accepted by~~ the individual and the individual's case manager. The ~~accepted~~agreed upon rate shall be reflected on the individual's person-centered services plan.

(F) ~~The Ohio department of aging (~~ODA~~)~~ shall establish unit rates for the services listed in this paragraph. No service shall have both a regional and statewide rate set pursuant to this rule.

(1) Statewide unit rates shall be established and used for the following services:

(a) Adult day ~~services~~;

~~(b) Emergency response system services;~~

~~(c)~~(b) Enhanced community living ~~services~~;

~~(d)~~(c) Home care attendant ~~services~~;

(d) Home delivered meals

(e) Out-of-home respite ~~services~~;

(f) Personal care ~~services~~

(g) Personal emergency response system; and

~~(g)~~(h) Waiver nursing ~~services~~.

(2) The services in paragraphs (F)(1)~~(d)~~(c), (F)(1)(f), and (F)(1)(h) of this rule, when rendered consecutively during the same visit to more than one but ~~less~~fewer than four PASSPORT individuals in the same household, as identified in the individuals' person-centeredservice plans, shall be ~~reimbursed~~paid ~~using a~~

~~group rate equal~~ to one hundred per cent of the provider's per unit rate set in accordance with paragraph (C) of this rule for one PASSPORT individual and paid a group rate for each . ~~The provider shall be reimbursed seventy-five per cent of the provider's per unit rate for~~ each subsequent PASSPORT individual in the household receiving services during the visit.

(G) ODA shall establish regional unit rates for the services listed in this paragraph pursuant to the methodology in paragraph (C)(3) of this rule. No service shall have both a regional and statewide rate set pursuant to this rule.

(1) Regional unit rates shall be set for the following services:

(a) Adult day ~~services~~ transportation;

~~(b) Home delivered meals services;~~

~~(c)~~(b) Homemaker ~~services~~;

~~(d)~~(c) Social work counseling ~~services~~;

~~(e)~~(d) Nutritional consultation ~~services~~; and

~~(f) ;~~

~~(g)~~(e) Independent living assistance ~~services~~.

(2) Adult day ~~service~~ transportation services rendered simultaneously by the same provider to more than one individual residing in the same household and traveling in the same vehicle to the same destination shall be ~~reimbursed~~paid using a group rate equal to seventy-five per cent of the provider's regional unit rate.

(3) Personal care ~~services, , that are~~ rendered during the same visit by the same provider to more than one but less than four PASSPORT individuals in the same household, as identified in the individuals' person-centered services plans, shall be ~~reimbursed~~ paid ~~using a group rate equal to~~ one hundred per cent of the provider's ~~regional~~ per unit rate set in accordance with paragraph (C) of this rule for one PASSPORT individual and paid the group rate. ~~The provider shall be reimbursed seventy-five per cent of their regional per unit rate~~ for each subsequent PASSPORT individual in the household receiving services during the visit.

~~(4) Homemaker services may be participant directed services in which the individual enrolled on PASSPORT or their authorized representative, acting on the individual's behalf, may negotiate reimbursement rates.~~

~~(a) The negotiated rate shall be reviewed by the individual's case manager and reflected on the individual's person-centered service plan prior to service delivery.~~

~~(b) Should the individual choose not to negotiate a rate of reimbursement the service shall be reimbursed in accordance with paragraph (G) of this rule. The accepted rate shall be reflected on the individual's person-centered service plan.~~

(H) The services in this paragraph are participant directed and the individual may negotiate unit rates with providers.

(1) The participant directed services include:

(a) Alternative meals ~~service~~; and

(b) Choices home care attendant ~~services~~.

(2) The individual shall have in effect, before choices home care attendant services are delivered, a signed provider agreement with each ODA-certified participant-directed individual provider delivering services to the individual. The provider agreement shall:

(a) Include the rate ~~of reimbursement~~ negotiated with the provider;

(b) Specify the time period the rates shall be in effect;

(c) Base rates on the units of service as set forth in Chapter 173-39 of the Administrative Code; and

(d) Be signed by the individual receiving the choices home care attendant service and the HCBS provider.

(3) The rates negotiated by the individual with providers of services in ~~this~~ paragraph (H) shall not exceed the maximum allowed per unit of service as specified in appendix A to rule 5160-1-06.1 of the Administrative Code. The negotiated rate shall be reviewed by the individual's case manager and reflected on the individual's person-centered service plan prior to service delivery.

(4) Should the individual choose not to negotiate a rate ~~of reimbursement~~ for any of the services in ~~this~~ paragraph (H), the service shall be ~~reimbursed~~paid at a rate ~~proposed by~~agreed upon by the provider and ~~accepted by~~ the individual and the individual's case manager. The ~~accepted~~ agreed upon rate shall be reflected on the individual's person-centered services plan.

(I) The Ohio department of medicaid, or its designee, shall evaluate unit rates within two years of the effective date of this rule and every two years thereafter.

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5160-44-11 **Nursing facility-based level of care home and community-based services programs: home delivered meals.**

(A) The following definitions are applicable to this rule:

(1) "Dietitian" and "licensed dietitian" mean a person with a current, valid license to practice dietetics under section 4759.06 of the Revised Code.

(2) "Home delivered meals" is a meal delivery service based on an individual's need for assistance with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary or specialized nutritional needs, including kosher meals, as ordered by a licensed healthcare professional within his or her scope of practice.

(3) "Special diet" means a diet ordered by a licensed healthcare professional whose scope of practice includes ordering special diets based upon, and adjusted to, the individual's assessed needs. A special diet is limited to:

(a) Nutrient adjusted diets, including high protein, no added salt and no concentrated sweets;

(b) Volume adjusted diets, including small, medium and large portions;

(c) The use of finger foods or bite-sized pieces for an individual's physical needs; or

(d) Mechanically altered food (i.e., the texture of food is altered by chopping, grinding, mashing or pureeing so that it can be successfully chewed and safely swallowed).

(4) "Therapeutic diet" means a diet ordered by a licensed healthcare professional whose scope of practice includes ordering therapeutic diets, including:

(a) As part of the treatment for a disease or clinical condition;

(b) To modify, eliminate, decrease or increase certain substances in the diet; or.

(c) To provide mechanically altered food when indicated.

(B) Meal specifications.

(1) Meals are single portions that are:

(a) Ready to eat; or

(b) Frozen, vacuum-packed, modified-atmosphere-packed or shelf-stable.

(2) Each meal shall:

(a) Include clear instructions on how to safely maintain, heat, reheat and/or assemble the meal.

(b) Adhere to the current "Dietary Guidelines for Americans" (www.health.gov/dietaryguidelines/).

(c) Provide at least thirty-three per cent of the dietary reference intakes;

(d) Meet state and local food safety and sanitation requirements; and

(e) Adhere to the individual's medical restrictions as set forth in their person-centered services plan.

(3) Meal menus shall be approved in writing by a dietitian who is currently registered with the commission on dietetic registration, and who is also a licensed dietitian when the state in which the dietitian is located licenses dietitians.

(a) Providers shall furnish each individual with home delivered meals that, as much as possible, accommodate the individual's religious, cultural, ethnic, and dietary preferences, including kosher meals.

(b) Providers shall publish their current menu and ingredient information on their websites and offer written menus and ingredient information to individuals.

(4) Meal delivery shall be specified in the person-centered services plan. The plan shall include the type and amount of meals to be furnished, as well as the frequency.

(a) Up to two meals per day may be provided.

(b) Planned multiple meal delivery may include meals for up to seven days that are compliant with food storage and safety requirements.

(c) For the purposes of this rule, method of delivery verification shall include:

(i) The individual's, his or her authorized representative's or other designee's signature upon delivery; or

(ii) The delivery driver's attestation that delivery occurred. Nothing shall prohibit the provider from using an electronic system to verify delivery.

(d) If a provider uses a common carrier to deliver meals, the provider shall verify the success of the delivery by using the method in paragraph (B)(4)(c) of this rule or by retaining the common carrier's tracking statement or returned postage-paid delivery invoice.

(e) The provider shall replace any item lost or stolen between the time of delivery and receipt by the individual at no cost to the individual, the Ohio department of medicaid (ODM), the Ohio department of aging (ODA) or their designee.

(C) Limitations.

(1) Meals shall not be:

(a) Processed, frozen, pre-packed and commercially available to the general public for purchase; or

(b) Provided in order to supplant or replace the purchase of food or groceries for others.

(2) A provider may deliver specifically identified items that are packaged in larger than single servings, but in no more than a one-week quantity that is compliant with food storage and safety requirements.

(3) The type of meal and frequency of delivery shall not be for provider convenience.

(D) Provider qualifications.

(1) A provider of home delivered meals shall provide and maintain evidence of:

(a) A current, valid food operations or other applicable license or certificate as required by licensing or regulatory agencies where the meal is produced.

(b) Good standing with all applicable federal, state and local regulatory agencies; and

(c) Meeting licensing requirements for safety, storage, sanitation and other applicable provisions for food service.

(2) The provider shall develop, implement and maintain evidence of a training plan that includes orientation and annual continuing education.

(a) The provider shall ensure anyone who participates in meal preparation, handling or delivery receives orientation on topics relevant to the person's job duties before they perform those duties.

(b) The provider shall ensure anyone who participates in meal preparation, handling or delivery completes continuing education annually on topics relevant to the person's job duties.

(E) Delivery requirements.

(1) Delivery shall be based on a routine delivery date and range of time.

(2) Written or electronic delivery instructions shall be provided to the delivery driver.

(3) The provider shall notify the individual if meal delivery will be delayed or will not occur as planned.

(4) The provider shall ensure that delivery provided by commercial or common carrier meets applicable federal, state and local food safety, storage and sanitation requirements.

(F) Documentation requirements.

(1) The provider shall maintain a clinical record for each individual served that shall include:

(a) Initial and all subsequent person-centered services plans;

(b) All dietary orders (including therapeutic and/or special diets) and instructions prepared by the applicable medical professional; and

(c) A record of the established delivery date and time.

(2) The provider shall maintain documentation of meal delivery, including:

(a) The individual's name;

(b) The date, time and number of meals in the delivery;

(c) Verification of delivery in accordance with the individual's person-centered services plan;

(d) Verification that the individual was notified if service delivery was not provided within the established delivery date or time; and

(e) Verification that the individual has been furnished clear instructions about how to safely heat, reheat and assemble each meal.

(3) The provider shall document and retain a written record of completed orientation and continuing education including the topics covered during the orientation and continuing education.

(4) The provider shall maintain documentation of the following:

(a) All licensure or certification documents required by this rule;

(b) All local licensing or regulatory agency inspection reports and documented findings, any resulting plans of correction and any follow up reports; and

(c) All United States department of agriculture inspection reports and documented findings, any resulting plans of correction and any follow-up reports.

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5160-44-16 **Nursing facility-based level of care home and community-based services programs: personal emergency response systems.**

(A) Personal emergency response systems (PERS) is a service with a monitoring, reminder and/or reporting component available to support individuals' independence in the community. PERS include telecommunications equipment, a central monitoring station (station), and a medium for two-way, hands-free communication between the individual and the station. Personnel at the station respond to an individual's alarm signal via the individual's PERS equipment.

(B) PERS equipment shall be appropriate to meet the assessed needs of the individual as authorized on the individual's person-centered services plan and shall include:

(1) Activation devices that are wearable and water-resistant. Water resistance shall meet a generally-accepted industry standard for water resistance to a level matching the individual's assessed needs and preferences.

(2) An internal battery providing at least twenty-four hours of power without recharging. Notification shall be sent to the station if the battery level is low.

(3) Devices to accommodate varying needs and preferences of the individual.

(C) PERS does not include:

(1) Remote video monitoring of the individual in his or her home.

(2) Systems that only connect to emergency service personnel.

(D) PERS provider requirements. The provider shall:

(1) Ensure and maintain a record of the successful completion of training on how to respond to alarm signals by each staff member whose job duties include responding to alarm signals at the station.

(2) Ensure each individual is able to choose the PERS device that meets his or her assessed needs and preferences as authorized by the individual's person-centered services plan.

(3) Install and activate the individual's PERS equipment no later than seven days after the date PERS has been authorized on the individual's person-centered services plan by the Ohio department of medicaid (ODM), the Ohio department of aging (ODA) or their designee.

(4) Furnish each individual receiving PERS with training including:

(a) An initial face-to-face demonstration on how to use their PERS equipment; and

(b) A successful return demonstration by the individual of all components of the PERS equipment and monthly testing.

(5) Ensure the availability of language assistance in the event the individual has limited English language proficiency.

(6) Prior to activating PERS equipment, the provider shall work with the individual and case manager to develop an initial written response plan regarding how to proceed when an alarm is signaled. The plan shall be updated upon the individual's request.

(a) The written response plan shall include a summary of the individual's information regarding medical diagnosis, treatment and preferences, as well as the contact information for the individual's designated responder.

(i) For the purpose of this rule, a designated responder is a person or organization identified in an individual's written response plan who the station contacts if the individual signals an alarm and requires assistance from the designated responder.

(ii) The provider shall identify emergency service personnel on the written response plan when the individual does not otherwise provide a designated responder or when only one designated responder is provided.

(b) The provider shall notify the designated responder when activating the individual's PERS equipment and on an annual basis thereafter as part of the monthly service. At a minimum, notification shall include directions on how to respond when an alarm is signaled.

(c) Upon notification that an individual's designated responder stops participating, the provider shall work with the individual and ODM, ODA or their designee to identify a new designated responder in the written response plan.

(7) At no additional cost to the individual, ODM, ODA, or their designee, replace any malfunctioning PERS equipment no later than twenty-four hours after it is notified of the malfunction, or no later than twenty-four hours after the malfunction is detected through the monthly testing of equipment, unless the

malfunction is due to the individual's apparent misuse, abuse, or negligence of the equipment.

(8) As part of its monthly service, provide ongoing customer support to the individual, designated responder, ODM, ODA and its designee upon request of one or more of those parties.

(9) If the provider cannot assist an individual with an assessed need, the provider shall notify ODM, ODA or their designee, in writing of the service limitations before the provider is included in the individual's person-centered services plan.

(10) Employ staff to comprise a central monitoring station located in the United States or may subcontract with another company to use a station located in the United States to provide the station component of the PERS.

(11) Maintain a primary system to receive and respond to alarm signals from individuals twenty-four hours a day, every day of the year;

(12) Maintain a secondary system to respond to all incoming alarm signals in case the primary system is unable to respond to alarm signals;

(13) Respond to each alarm signal no more than sixty seconds after it receives the alarm signal;

(14) Notify ODM, ODA or their designee of any emergency involving an individual no more than twenty-four hours after the individual sends the alarm signal;

(15) Notify ODM, ODA or their designee when a pattern of frequent false alarms has been established for an individual;

(16) Contact emergency service personnel in the event a provider receives an alarm signal, but the station cannot reach a designated responder; and

(17) In the event of an emergency, remain in communication with the individual through the two-way communication feature of the PERS equipment until a designated responder or emergency service personnel arrives in the individual's home, the emergency subsides, or after it is determined there is no emergency (e.g. false alarm).

(E) PERS providers shall maintain the following documentation for each individual receiving PERS:

(1) Date and time of equipment delivery and installation;

(2) A copy of the individual's initial and all subsequent written response plans;

(3) Date the individual and designated responder received initial and annual notification from the PERS provider as required by paragraph (D)(6)(b) of this rule;

(4) Date, time and results of monthly testing; and

(5) Date, time and summary of actions taken regarding service-related contacts.

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5160-46-06 **Ohio home care waiver program: reimbursement rates and billing procedures.**

(A) Definitions of terms used for billing and calculating rates.

(1) "Base rate," as used in table A, column 3 of paragraph (B) of this rule, means the amount reimbursed by the Ohio department of medicaid (ODM) for the first thirty-five to sixty minutes of service delivered.

(2) "Billing unit," as used in table B, column 3 of paragraph (B) of this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).

(3) "Caretaker relative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(4) "Group rate," as used in paragraph (D)(1) of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.

(5) "Group setting" means a setting in which:

(a) A personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ~~Ohio department of medicaid (ODM)~~ ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(b) A waiver nursing service provider furnishes the same type of services to either:

(i) Two or three individuals at the same address. The services provided in the group setting can be either the same type of ~~Ohio department of medicaid (ODM)~~ ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(ii) Two to four individuals at the same address if all of the individuals receiving ODM-administered waiver nursing services are:

(a) Medically fragile children, and

(b) Siblings, and

(c) Residing together in the home of their caretaker relative. The services provided in the group setting must be ODM-administered waiver nursing services.

(6) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.

(a) For the billing codes in table B of paragraph (B) of this rule, the medicaid maximum rate is set forth in column (4).

(b) For the billing codes in table A of paragraph (B) of this rule, the medicaid maximum rate is:

(i) The base rate as defined in paragraph (A)(1) of this rule, or

(ii) The base rate as defined in paragraph (A)(1) of this rule plus the unit rate as defined in paragraph (A) (7) of this rule for each additional unit of service delivered, or

(iii) The unit rate as defined in paragraph (A)(7)(b) of this rule.

(7) "Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of the "Social Security Act," (42 U.S.C. 1382c(a)(2) or (3)) (as in effect on January 1, ~~2017~~2018).

(8) "Modifier," as used in paragraph (D) of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.

(9) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount reimbursed by ~~Ohio medicaid~~ ODM for each fifteen minutes of service delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. ~~Ohio medicaid~~ ODM will reimburse a maximum of only one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(B) Billing code tables.

Table A

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Base rate	Unit rate
T1002	Waiver nursing services provided by an agency RN	$47.40	$8.72
T1002	Waiver nursing services provided by a non-agency RN	$38.95	$7.03
T1002	Waiver nursing services provided by a non-agency RN (overtime)	$50.82	$10.01
T1003	Waiver nursing services provided by an agency LPN	$40.65	$7.37
T1003	Waiver nursing services provided by a non-agency LPN	$33.20	$5.88
T1003	Waiver nursing services provided by a non-agency LPN (overtime)	$43.00	$8.33
T1019	Personal care aide services provided by an agency personal care aide	$23.12	$3.84
T1019	Personal care aide services provided by a non-agency personal care aide	$18.64	$2.95
T1019	Personal care aide services provided by a non-agency personal care aide (overtime)	$22.59	$4.16

Table B

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Billing unit	Medicaid maximum rate
H0045	Out-of-home respite services	Per day	$199.82
S0215	Supplemental transportation services	Per mile	$0.38

S5101	Adult day health center services	Per half day	$32.48
S5102	Adult day health center services	Per day	$64.94
S5160	~~Emergency response services~~ Personal emergency response systems	Per installation and testing	~~$44.96~~ $32.95
S5161	~~Emergency response services~~ Personal emergency response systems	Per monthly fee	~~$44.96~~ $32.95
S5165	Home modification services	Per item	Amount prior-authorized on the all services plan
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the all services plan
S5170	Home delivered meal services - standard meal	Per meal	~~$6.99~~ $6.50
S5170	Home delivered meal services - therapeutic or kosher meal	Per meal	$8.68

(C) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.

(D) Required modifiers.

(1) The "HQ" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement as a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.

(2) The "TU" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 and the entire claim is being billed as overtime.

(3) The "UA" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 and only a portion of the claim is being billed as overtime.

(4) The "U1" modifier must be used when a provider submits a claim for billing code T1002 and the individual enrolled on the Ohio home care waiver is receiving infusion therapy.

(5) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(7) The "U4" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

(8) The "U6" modifier must be used when a provider submits a claim for billing code S5170 for a therapeutic or kosher home delivered meal.

(E) Claims shall be submitted to, and reimbursement shall be provided by, ODM in accordance with Chapter 5160-1 of the Administrative Code.

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