5123:2-9-31 **Home and community-based services waivers - homemaker/ personal care daily billing unit for sites where individuals enrolled on the individual options waiver share services.**

(A) Purpose

The purpose of this rule is to establish the payment process for homemaker/personal care (HPC) when individuals share the services of the same provider at the same site as part of the home and community-based services (HCBS) individual options waiver administered by the Ohio department of developmental disabilities (the department). This rule establishes a daily billing unit for individuals/sites that qualify, which shall be used instead of the fifteen-minute billing unit established in rule 5123:2-9-06 of the Administrative Code. All other requirements of rule 5123:2-9-06 of the Administrative Code apply to the HPC daily billing unit.

(B) Definitions

(1) "Cost projection tool" means the web-based analytical tool, developed and administered by the department, used to project the cost of HCBS waiver services identified in the individual service plans (ISPs) of individuals enrolled on individual options and level one HCBS waivers. The department shall publish any changes to the cost projection tool thirty days prior to implementation.

(2) "Daily billing unit" means the amount of a provider's payment that is apportioned to each individual who lives at the site and shares HPC services with others. The daily billing unit is determined via the daily rate application in accordance with planning information entered by the county board of developmental disabilities (county board) and actual service information entered by the provider of HPC services.

(3) "Daily rate application" means the web-based analytical tool, developed and administered by the department, used by county boards to apportion the cost of HPC services identified in the ISPs of individuals who share the services of the same provider at the same site as part of the HCBS individual options waiver.

(4) "Direct service hours" means the direct staff time spent delivering HPC services. A direct service hour is comprised of four fifteen-minute billing units.

(5) "Fifteen-minute billing unit" means a billing unit that equals fifteen minutes of service delivery time or is greater or equal to eight minutes and less than or equal to twenty-two minutes of service delivery time.

(6) "Service documentation" means all records and information on one or more documents, including documents that may be created or maintained in

electronic software programs, kept in a manner as to fully disclose the nature and extent of services delivered that shall include the items delineated in paragraphs (F)(2)(a) to (F)(2)(h) of this rule to validate payment for medicaid services.

(7) "Site span" means a period of time where there are no changes to the estimated total costs or estimated total direct service hours for a site where individuals share HPC services of a provider. An individual may have one or more site spans during one waiver span.

(C) Circumstances excluded from the daily billing unit approach

(1) Individuals who receive HPC services and supports in adult foster care settings shall do so in accordance with rule 5123:2-13-06 of the Administrative Code. A daily billing unit for HPC shall not be billed on the same day as adult foster care.

(2) Individuals who do not share the HPC services of the same provider at the same site shall remain on the fifteen-minute billing unit approach established in rule 5123:2-9-06 of the Administrative Code.

(3) Individuals who share occasional or time-limited services of a provider in addition to their primary residential provider shall remain on the fifteen-minute billing unit approach established in rule 5123:2-9-06 of the Administrative Code for the occasional or time-limited HPC services of their non-residential provider. Examples include but are not limited to:

(a) Individuals who live together and share HPC services of a provider and who use a second HPC provider for recreational activities; and

(b) Individuals who live in different homes who travel with a provider who is not their residential provider to a recreational event such as bowling, respite, or camp on a monthly or weekly basis.

(4) Individuals who live alone and share services with a neighbor or other eligible person.

(D) Calculation of the individual daily billing unit

(1) The process for assigning a funding range, determining an individual funding level, establishing behavior support and/or medical assistance HPC rate modifications, and projecting the cost of an individual's services, set forth in rule 5123:2-9-06 of the Administrative Code, shall be followed.

(2) For situations where there is at least one staff person serving more than one individual during sleep hours and of those individuals, at least one individual's ISP calls for routine HPC during the sleep hours, while at the

same time at least one other individual has a need for on-site/on-call (OSOC), the provider shall be paid at the routine HPC rate as set forth in rule 5123:2-9-06 of the Administrative Code, which shall be determined by the number of awake staff and the number of individuals who are receiving routine HPC. The cost of that rate shall be apportioned so that the individuals receiving OSOC shall be charged the OSOC rate as set forth in rule 5123:2-9-06 of the Administrative Code and the individuals receiving routine HPC shall be charged an equal share of the remainder of the cost. The following examples are provided to illustrate how the rates are determined and how the cost of those rates is apportioned. The examples utilize rates in rule 5123:2-9-06 of the Administrative Code for cost-of-doing-business category one.

(a) Example 1. Four individuals live together and have one staff person during sleep hours. One individual receives routine HPC and the other three individuals receive OSOC.

Example 1

Routine HPC base rate 1:1	$4.52
OSOC 1:4	$3.24
Individual 1 (1/4 of OSOC 1:4)	$.81
Individual 2 (1/4 of OSOC 1:4)	$.81
Individual 3 (1/4 of OSOC 1:4)	$.81
Individual 4 (routine HPC base rate - remainder)	$2.09
Total payment for 1 staff	$4.52

(b) Example 2. Five individuals live together and have one staff person during sleep hours. Two individuals receive routine HPC and the other three individuals receive OSOC.

Example 2

Routine HPC base rate 1:2	$4.83
OSOC 1:5	$3.24
Individual 1 (1/5 of OSOC 1:5)	$.648
Individual 2 (1/5 of OSOC 1:5)	$.648
Individual 3 (1/5 of OSOC 1:5)	$.648

Individual 4 (routine HPC base rate - 1/2 remainder)	$1.443
Individual 5 (routine HPC base rate - 1/2 remainder)	$1.443
Total payment for 1 staff	$4.83

(3) Using the cost projection tool, the service and support administrator or other county board designee, with input from members of the individual's team, shall project the service utilization for the individuals who share services based on factors including but not limited to: a typical usage pattern and identified waiver span; adjustments based on past history, holidays, day service site closings, and weekends; and other anticipated changes to direct service hours. The result shall include total planned HPC costs based on ISPs for the site and a total projected number of service hours for the site. These projections include any individual's prior authorization requests that have been approved pursuant to rule 5101:3-41-12 of the Administrative Code.

(4) The daily rate application shall include:

(a) Total planned HPC costs for the site based on ISPs for individuals who are sharing HPC services of the same provider at the site;

(b) Total estimated HPC hours for the site to be provided; and

(c) Each individual's authorized funding for HPC services.

(5) After HPC services are provided at the site, the provider shall enter into the daily rate application, the number of direct service hours rendered for all individuals for a specific seven-day time span, or up to a fourteen-day time span if the daily billing unit is expected to exceed the maximum medicaid payment rate for the seven-day time span, and the specific dates that each individual received HPC services at the site. Using the results from the cost projection tool, the daily rate application determines the provider's direct service hourly rate for that site. The daily rate application then calculates the maximum HPC payment to the provider for that period. The daily rate application then determines how the total payment to that provider for that period shall be apportioned to each individual's authorized budget, resulting in a daily billing unit for each individual for each day that services were provided. The provider then uses that information to prepare a claim for payment.

(6) When changes occur at the site that affect the total estimated direct service hours, total planned HPC costs based on ISPs, or an individual's predicted ongoing participation at the site, the county board shall enter changes into the cost projection tool for a new, prospective site span. These changes shall be made with any necessary changes to the ISP and the cost projection and

payment authorization for the individual(s) living at the site who will be affected by these changes.

(a) If, during a site span, there is a change of service needs for an individual that may impact the total estimated direct service hours, total planned HPC costs based on ISPs, or an individual's predicted ongoing participation at the site, the provider shall notify the county board. The provider and the county board shall work together to identify potential solutions.

(b) If the individual/guardian, county board, or provider wishes to convene a meeting to discuss a change of service needs for an individual during a site span, that meeting shall occur within ten working days of the day the request was made. Discussion shall occur in accordance with paragraph (C)(6) of rule 5123:2-9-06 of the Administrative Code.

(E) The director of the department reserves the right to allow a provider of HPC services to continue to use the fifteen-minute billing unit in the event of a unique and/or extenuating circumstance. This right shall be exercised in consultation with the Ohio department of job and family services (ODJFS) as the single state medicaid agency.

(F) Service documentation requirements

(1) The requirements of paragraph (B) of rule 5123:2-9-05 of the Administrative Code do not apply to service documentation for HPC when individuals share the services of the same provider at the same site.

(2) The service documentation for HPC when individuals share the services of the same provider at the same site shall include each of the following to validate payment for medicaid services:

(a) Date of service.

(b) Place of service.

(c) Name of individual(s) receiving services each day.

(d) Description and details of the services delivered that directly relate to the services specified on the individual's approved ISP as the services to be provided.

(e) Medicaid identification number of the individual(s) receiving services.

(f) Name of provider.

(g) Provider identifier/contract number.

(h) Signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider, or an electronic process approved by the department.

(G) Payment standards

(1) The billing process and payment for HPC services when individuals share the services of the same provider at the same site shall be at the daily billing unit for each individual based on that individual's apportioned share of the services rendered at the site and the number of days each person receives services pursuant to the daily rate application. The service codes for the HPC daily billing unit are contained in the appendix to this rule.

(2) Providers shall be paid at the lower of the provider's usual and customary rate or the statewide HPC rates established in appendix A to rule 5123:2-9-06 of the Administrative Code.

(3) Agency providers of HPC may bill for each day the individual receives HPC through the agency.

(4) Independent providers of HPC may bill for each day the HPC service is delivered by the provider.

(5) Payment for HPC does not include room and board, items of comfort or convenience, or costs for the maintenance, upkeep, and improvement of the home.

(6) ODJFS retains the final authority to establish payment rates for all waiver services included in HCBS waivers administered by the department.

(H) Monitoring

(1) Providers, county boards, and the department shall have access to both utilization reports and reports generated by the daily rate application in order to monitor estimated services and actual services provided at each specific site. This information shall be made available to ODJFS upon request.

(2) The department shall monitor the ongoing progress of the daily billing unit approach through a series of fiscal control and quality assurance procedures including: validation of total expenditures and total hours that are entered by the county board into the cost projection tool; verification that daily billing units are supported by appropriate documentation; and verification that provider service hours rendered are reported appropriately. Each type of procedural monitoring shall take place in each region of the state and shall be summarized in a report to ODJFS every six months.

(3) ODJFS reserves the right to perform independent oversight reviews as part of its general oversight functions, in addition to the department's monitoring activities described in paragraph (H)(2) of this rule.

(I) Due process rights and responsibilities

(1) Any recipient or applicant for waiver services administered by the department may utilize the process set forth in section 5101.35 of the Revised Code, in accordance with division 5101:6 of the Administrative Code, for any purpose authorized by that statute and the rules implementing the statute. The process set forth in section 5101.35 of the Revised Code is available only to applicants, recipients, and their lawfully appointed authorized representatives. Providers shall have no standing in an appeal under this section.

(2) Applicants for and recipients of waiver services administered by the department shall use the process set forth in section 5101.35 of the Revised Code for any challenge related to the administration and/or scoring of the ODDP or to the type, amount/level, scope, or duration of services included on or excluded from an ISP or individual behavior plan addendum. A change in staff to waiver recipient service ratios does not automatically result in a change in the level of services received by an individual.

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