

# 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 2

Rule Number(s): 5160-44-12; 5160-44-14; 5160-44-26; 5160-46-04

Included for Informational Purposes Only: 5160-46-06, 5160-58-04

Date: February 26, 2019

Rule Type:



New

5-Year Review



Amended

Rescinded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. 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

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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 two of the HCBS waiver alignment collaboration and includes service alignment efforts that will result in a budget impact.

**5160-44-12 “Nursing facility-based level of care home and community-based services programs: home maintenance and chore services,”** is being proposed as new to implement home maintenance and chore services in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, provider qualifications and clinical record keeping requirements.

**5160-44-14 “Nursing facility-based level of care home and community-based services programs: community integration services,”** is being proposed as new to implement community integration services in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, authorization process and amount, service limitations and provider requirements.

**5160-44-26 “Nursing facility-based level of care home and community-based services programs: community transition services,”** is being proposed as new to implement community transition services in Chapter 5160-44 of the Administrative Code. This rule sets forth the service description, limitations, provider qualifications and requirements, and clinical record keeping requirements.

**5160-46-04 “Ohio home care waiver: definitions of the covered services and provider requirements and specifications,”** is being proposed for amendment to align with implementation of HCBS rules in Chapter 5160-44 of the Administrative Code. This rule sets forth the covered services and provider requirements for nursing facility-based HCBS waivers administered by ODM. The personal care aide service is being modified due to the creation of home maintenance and chore services as set forth in new OAC rule 5160-44-14.

**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**

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**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;"*

Thus, 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 that providers must meet in order 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)?**

ODM and ODA have been collaborating to align and bring greater consistency to their home and community-based services waiver programs. Alignment efforts will result in the addition of three new services to the Ohio Home Care Waiver (i.e., community integration, community transition, and home maintenance and chore services), and modification/replacement of existing services in the MyCare, PASSPORT and Assisted Living waivers. Waiver service specifications, provider requirements and reimbursement rates will now be consistent across both waiver systems.

Additionally, the public purpose of these regulations is also to assure the health and welfare of individuals enrolled in an ODM or ODA-administered HCBS waiver as required by 42 C.F.R. 441.302(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.

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

The effectiveness of these regulations will be measured in several ways. First, regarding individuals served by the ODM- and ODA-administered waivers, it will be evident through their successful transition from institutional settings into the community using the new waiver services.

Community transition services will permit the purchase of necessary goods and services to help individuals create a safe living environment. Ongoing success will also be impacted using community integration services, which teach individuals basic skills necessary to be independent, and/or perform certain tasks for individuals, as appropriate. Home maintenance and chore services, i.e., home repairs, pest control and assistance with heavy chores, will ensure an individuals' ongoing health, safety and welfare at home, promote independence and self-sufficiency, and thereby help sustain the individual in the community.

Second, success will be measured through a provider's compliance with waiver 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/webinar) and plays a critical role in the ODM and ODA HCBS waiver alignment initiative. All rules in this package have been provided to the HCBS Rules Workgroup for review and comment.

The HCBS Rules Workgroup email group includes approximately 900 members. The workgroup consists of individuals enrolled on ODM-administered waivers, agency and independent service providers and members of no less than the following organizations:

Ability Center  
Homes  
Caresource  
CareStar

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Coalition of Community Living  
Council on Aging  
Creative Housing/Creative Renovations  
Home Care by Black Stone  
Home Care Network  
LeadingAge Ohio  
LEAP  
Molina Healthcare  
Ohio Academy of Senior Health Sciences, Inc.  
Ohio Assisted Living Association  
Ohio Association of Area Agencies on Aging  
Ohio Association of Senior Centers  
Ohio Council for Home Care and Hospice  
Ohio Department of Developmental Disabilities  
Ohio Health Care Association  
Ohio Long Term Care Ombudsman  
Ohio Olmstead Task Force  
Public Consulting Group (PCG)  
Senior Resource Connection  
United Healthcare

**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 provided a tremendous amount of feedback related to the rule drafts. Often the suggested edits were incorporated, and updated drafts were 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.

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**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, their 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 the implementation of 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 via 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 3,879 non-agency personal care aides, 1,641 registered nurses (RN)/licensed practical nurses (LPN), and 54 home care attendants serving individuals enrolled on an ODM-administered waiver. There are also 735 Medicare-certified home health agencies, 61 otherwise-accredited agencies and approximately 578 ancillary service providers that also furnish services to individuals.

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

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**OAC rule 5160-44-12** requires that home maintenance and chore service providers comply with the requirements necessary to become an ODM-approved provider or an ODA-certified provider for the specific type of task they are going to perform, including have all necessary and required licensure in place (e.g., electrician, plumber, contractor, etc.).

**OAC rule 5160-44-14** requires that community integration service providers comply with the requirements necessary to become an ODM-approved provider or an ODA-certified provider. Staff must have a high school diploma, GED, or a minimum of one year of relevant supervised work experience with a public health, human services or other community service agency, the ability to understand written activity plans and have experience advocating on behalf of individuals with chronic illnesses, behavioral health conditions, physical disabilities or developmental disabilities. Supervisors must possess a current and valid license in the state of Ohio as a registered nurse, licensed practical nurse, licensed social worker or licensed independent social worker; or a bachelor's or associate's degree in human ecology, dietetics, counseling, gerontology, social work, nursing, public health, health education or another related field; or at least three years of employment experience providing community-based social services or job coaching.

**OAC 5160-44-26** requires that community transition service providers comply with the requirements necessary to become an ODM-approved provider or an ODA-certified provider. Specifically, they must be a waiver agency, non-agency, a transition coordination service provider under contract with ODM that is also an ODM-approved or ODA-certified waiver agency or non-agency provider; or an ODA-certified assisted living waiver service provider.

**OAC rule 5160-46-04** requires providers to comply with all the requirements outlined above. These requirements are being removed from this rule and implemented in the rules listed above. In addition, the new rule includes a requirement for home health agencies to be Medicare-certified or otherwise accredited by a national accreditation body. An adult day health center must provide for replacement coverage due to theft, property damage and/or personal injury. Personal care aides must have a certificate of completion of either a competency evaluation program or training and competency evaluation program approved and conducted by the Ohio Department of Health, or the Medicare competency evaluation program for home health aides. They must also obtain and maintain first aid certification. Supplemental transportation service providers must possess a valid driver's license. Supplemental transportation service providers must also maintain collision/liability insurance for each vehicle/driver and obtain and exhibit evidence of valid motor vehicle inspections from the Ohio Highway Patrol for all vehicles used to provide services. Nonagency drivers must possess collision/liability insurance and obtain and exhibit evidence of required motor vehicle inspections. Drivers must also obtain and maintain a certificate of completion of a course in first aid.

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Providers may incur costs associated with continuing education requirements and records retention pertaining to their service as set forth in these rules.

**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.*

A prospective provider can receive home health aide/competency training through adult vocational schools. An informal survey of courses approximates this cost at \$200-\$500 depending on the program and type of instruction. State tested nurse assistant (STNA) programs costs also vary but are generally around \$400.

The cost of 12 hours of continuing education each year for a home care attendant will vary by subject, source and location. Medicaid will not reimburse providers for time spent training.

First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about \$70-75. Tuition can range anywhere from \$50 to over \$110, with lower rates in more rural counties.

5160-46-04 requires agencies to be Medicare-certified and to execute provider agreements as a condition of participation and compliance. The certification process from start to finish can take six to nine months. Administrative staff involved invest as much as 80 or more hours to complete the initial Medicare certification process, and five or more hours per agency administrator to secure the provider agreement from a non-agency provider and/or an accredited agency. The cost of Medicare certification varies by agency and can be more than a \$250,000 endeavor depending on the number of staff hired to support the process. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

Providers must revalidate a provider agreement every 5 years and this includes a \$569 fee. The revalidation may take from one to two hours at a rate of \$29 an hour to complete the revalidation process. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

To maintain Medicare certification, a survey is required to be completed once every three years (or sooner, depending on the number of deficiencies found on the survey). This process is an on-going process for agencies. It is a compliance issue, keeping up with all the new rules and regulations. On average an agency spends a minimum of .5 FTE of a nurse's salary on this compliance piece and if it is a larger agency, it can be 1 to 1.5 FTEs. At \$29 per hour, that could

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amount to between \$60,000- \$90,000 per year. (This number does not include benefits).  
SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

"Otherwise accredited agencies" such as those accredited by The Joint Commission may spend approximately \$16,000 every three years for conducting their on-site survey. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

Agencies incur approximately \$190 in costs for RN assignment/oversight/supervision of aides at least every 60 days, or as often as every 14 days. OAC 5160-44-22 requires the RN to conduct a face-to-face visit with the LPN prior to initiating care, at least every sixty days, and at least each one hundred and twenty days (with the individual present) to evaluate that the LPN's provision of nursing services are in accordance with the plan of care. The cost of an RN visit, which is not reimbursed by ODM is \$31.50/hour. So, within the first four months the RN visits would equal at least \$126 or more that is not reimbursed by ODM. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

It is a challenge to determine the total cost of maintaining records because the number of documents needed, and time spent gathering these documents would be different for everyone. SOURCE *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

Training and competency testing have been estimated to cost an agency approximately \$2,704 for a group of ten potential personal care aides. More than \$2,200 of these costs are attributable to the cost of instruction (RN/PT instructors) over a 75-hour period. The actual aide handbook is estimated to cost approximately \$30 per person. Agencies also incur additional costs for wages, testing and materials. An independent provider can receive training through adult vocational schools (approximate cost: \$500). Some state tested nurse assistant (STNA) programs are Diversified Health Programs encompassing Aide Training to Medical Assistants. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

Twelve hours of continuing education each year is estimated to cost an agency approximately \$1,821 for a group of ten staff. This estimate includes nearly \$500 for the cost of materials/administrative costs/instruction and the remainder is for payment of wages to staff while they undergo training. Medicaid will not reimburse providers for time spent training. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

First aid training is estimated to cost an agency \$394 every two years for a group of 10 staff. This includes \$174 for the cost of materials/administrative costs/instruction and the remainder is for payment of wages to staff while they undergo training. Again, an independent provider would be responsible for training costs and would not be paid wages while receiving instruction. SOURCE: *Ohio Council for Home Care and Hospice and LeadingAge Ohio.*

Supplemental transportation as well as other waiver service providers incur \$23-\$26 in licensure fees. Additionally, transportation providers' auto insurance costs will vary by both city and vehicle. According to an analysis of auto insurance rates in Ohio conducted

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by valuepenguin.com, average minimum coverage premiums range from \$428 to \$1,428 per year.

**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.

5160-44-12

**Nursing facility-based level of care home and community-based services programs: home maintenance and chore services.**

(A) "Home maintenance and chore services" means a service that improves, restores or maintains a clean and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability. Home maintenance and chore services shall not exceed a total of ten thousand dollars in a calendar year per individual. Covered home maintenance and chore services include:

- (1) Minor home maintenance and repair including inspecting, maintaining, and repairing furnaces, including pilot lights and filters; inspecting, maintaining, and repairing water faucets, drains, heaters, and pumps; replacing or installing electrical fuses; plumbing and electrical repairs; repair or replacement of screens or window panes; fixing floor surfaces posing a threat to the individual's health, safety and welfare; and moving heavy items to provide safe ingress and egress.
- (2) Heavy household cleaning, including washing walls and ceilings; washing the outside of windows; non-routine washing of windows; removing, cleaning and rehanging curtains or drapery; and shampooing carpets or furniture.
- (3) Non-routine disposal of garbage posing a threat to the individual's health, safety and welfare.
- (4) Non-routine yard maintenance including snow removal posing a threat to the individual's health, safety and welfare.
- (5) Pest control and related tasks to prevent, suppress, eradicate, or remove pests posing a threat to the individual's health, safety and welfare.

(B) Home maintenance and chore services do not include:

- (1) Tasks of general utility (including routine yardwork), and not of direct medical or remedial benefit to the individual.
- (2) Jobs that add to the total square footage of the home.
- (3) Jobs that can be accomplished through existing informal or formal supports.
- (4) Jobs that are the legal or contractual responsibility of someone other than the individual (e.g., the landlord, etc.).

- (5) Jobs involving the removal of modifications and returning of property to its prior condition when the individual vacates the premises.
- (6) Replacement or repair of a previously approved home modification or home maintenance and chore job that has been damaged as a result of apparent misuse, abuse or negligence.
- (C) Home maintenance and chore services may be authorized up to one hundred and eighty consecutive days prior to an individual's transition from an institutional setting into the community. The service is not considered complete until, and the date of service for purposes of reimbursement shall be, the date on which the individual leaves the institutional setting. If an individual fails to transition into the community, the service is still reimbursable if all other requirements are met.
- (D) Home maintenance and chore services that are necessary to ensure the health, safety and welfare of the individual and will exceed the ten-thousand-dollar calendar year threshold may be considered for approval by the Ohio department of medicaid (ODM), Ohio department of aging (ODA) or their designee.
- (E) Authorization process.

  - (1) ODM, ODA or their designee may require the completion of an in-home evaluation by an appropriately qualified professional to determine the suitability of the immediate environment where the service will be performed and the viability of the completion of the service to improve independence and/or facilitate a healthy and safe environment.
  - (2) In consultation with the individual and/or caregiver(s), ODM, ODA or their designee and if required, the qualified professional, shall develop a referral that addresses the individual's home maintenance and chore service needs.
  - (3) Home maintenance and chore service providers shall submit a fixed cost proposal for the services submitted under the referral which shall be good for the term of the proposal.

    - (a) At a minimum, the proposal shall include all of the following:

      - (i) A breakdown of all the needed materials;
      - (ii) A breakdown of the costs of all the needed materials;
      - (iii) A breakdown of the labor costs;
      - (iv) A list of all permits that must be obtained;

- (v) An estimate of the time needed to complete the service;
    - (vi) A written statement of all warranties provided, including a warranty lasting at least one year from the date of final acceptance of work against defective workmanship, as applicable; and
    - (vii) A written guarantee that all materials, products and installed or furnished appliances perform their advertised function.
  - (b) A fixed cost proposal may be adjusted for good cause only if the proposal is adjusted in writing, and the adjustment is approved by ODM, ODA or their designee.
- (4) ODM, ODA, or their designee shall review all submitted proposals with the individual and shall approve the proposal with the lowest cost alternative that meets the individual's assessed needs and ensures the health, safety and welfare of the individual.
- (5) The provider shall be reimbursed for the actual cost of material and/or labor as identified in the proposal. Reimbursement may only be adjusted if the fixed cost proposal is adjusted pursuant to the requirements set forth in paragraph (E) (3)(b) of this rule.

(F) Provider requirements.

The provider shall:

- (1) Know and understand the individual's person-centered services plan related to home maintenance and chore services and personal preferences regarding the specific services to be performed.
- (2) Before performing a service, inform the individual and ODM, ODA, or their designee of any specific health or welfare risks expected, and coordinate times and dates of service to ensure minimal risk to the individual.
- (3) Before performing a service, obtain and maintain all permits and pre-inspections required by law or ordinance, or by a homeowners' association.
- (4) Comply with applicable federal, state, or local laws and homeowners' association requirements, as applicable.
- (5) Obtain the property owner's written consent prior to performing the service. This written consent shall reflect that the property owner has agreed to the maintenance, repair or other service.

- (6) Maintain and upon request, furnish proof of appropriate qualifications to perform services requiring specialized skills such as electrical, heating/ventilation, and plumbing work.
- (7) Maintain and upon request, furnish proof of licensure, insurance, and bonding for services from applicable jurisdictions.
- (8) Maintain and upon request, furnish a list of the chemicals or substances used for each proposal.
- (9) Furnish to the individual and ODM, ODA, or their designee a warranty that covers the workmanship and materials involved in performing the service, as applicable.
- (10) Provide documentation to ODM, ODA, or their designee that the service was completed in accordance with the agreed upon specifications using the materials and equipment cited in the proposal.
- (11) Provide documentation to ODM, ODA, or their designee that the service was tested, is in proper working order, and is usable by the individual, if applicable.
- (12) After completing, but before billing for the service, obtain and maintain any necessary post-inspections and post-inspection reports required by law, a home owners' association, or both to verify whether each episode of service meets federal, state and local laws or home owners' association requirements.
- (13) Repair any damage incidental to the service.
- (14) Obtain final written approval from the individual and the case manager after completion of the service.
- (G) Provider qualifications.
  - (1) Only an agency or non-agency provider that has been approved by ODM or certified by ODA as a medicaid waiver provider of home maintenance and chore service shall provide this service.
  - (2) Prior to performing a service, the provider shall have all necessary and required licensure in place.
- (H) Service verification: The provider shall obtain the individual's or authorized representative's signature and date of completion of the service to verify service delivery, verify the provider left the individual's home in satisfactory condition, and verify repair of any damages incidental to the service.

(I) Provider record retention. For each service furnished, the provider shall retain a record of compliance with all requirements set forth in rule 5160-44-31 of the Administrative Code, or with the requirements set forth in Chapter 173-39 of the Administrative Code for the PASSPORT Program. The record shall include:

- (1) Individual's name.
- (2) Date of service delivery.
- (3) A copy of the fixed cost proposal described in paragraph (D)(3) of this rule, including any approved adjustments.
- (4) Service description, including a comparison between the fixed cost proposal and the actual services provided.
- (5) Name of each person in contact with the individual.
- (6) List of chemicals or substances used.
- (7) All of the documents required in paragraphs (F), (G), and (H) of this rule.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02

5160-44-14

**Nursing facility-based level of care home and community-based services programs: community integration services.**

- (A) Community integration services are independent living assistance and community support coaching activities that are necessary to enable individuals to live independently and have access to, choice of, and an opportunity to participate in, a full range of community activities.
- (B) Independent living assistance helps individuals to manage their households and personal affairs, self-administer medications and retain their community living arrangements. It can be furnished through telephone support, in-person support or travel attendant activities, as applicable to the tasks performed. Tasks may include:
- (1) Reminding individuals to take their medications;
  - (2) Contacting individuals at times no other in-home services are being provided to confirm individuals are functioning safely in their home;
  - (3) Assisting with banking;
  - (4) Organizing and coordinating health records;
  - (5) Assisting with applications for public programs including homestead exemption, the home energy assistance program and subsidized housing;
  - (6) Monitoring and replenishing needed groceries (does not include cost of groceries);
  - (7) Assisting with business and personal correspondence;
  - (8) Accompanying individuals to their medical and other appointments; and
  - (9) Accompanying individuals on their errands and to other activities in the community.
- (C) Community support coaching includes providing information and training to an individual so the individual can achieve the community integration goals identified in his or her person-centered services plan. Skills training topics include:
- (1) How to manage finances;
  - (2) How to manage one's own health and wellness;

- (3) How to identify and access community and legal resources, and leisure, educational and recreational activities;
- (4) How to find a job;
- (5) How to manage one's own home;
- (6) How to navigate community-based transportation systems; and
- (7) How to build interpersonal, social and communication skills.

(D) Community integration service provider requirements.

- (1) Community integration services shall be furnished by Ohio department of medicaid (ODM) -approved agencies or Ohio department of aging (ODA) -certified agencies.
- (2) The provider shall comply with the requirements set forth in rule 5160-44-31 of the Administrative Code for an ODM-administered waiver program, or Chapter 173-39 of the Administrative Code for the PASSPORT waiver program.
- (3) The provider shall develop, implement and maintain evidence of a training plan that includes initial orientation and annual continuing education.
  - (a) The provider shall ensure anyone who furnishes community integration services receives orientation on topics relevant to the person's job duties before they perform those duties.
  - (b) The provider shall ensure anyone who furnishes community integration services completes a minimum of twelve hours of continuing education annually on topics relevant to the person's job duties.
- (4) Community integration service staff shall have:
  - (a) A high school diploma, general education diploma (GED) or a minimum of one year of relevant, supervised work experience with a public health, human services, or other community service agency.
  - (b) The ability to understand written activity plans (description of interventions and the dates/times the provider shall provide the interventions), execute instructions, document activities provided and the ability to perform basic mathematical operations.

- (c) Experience advocating on behalf of individuals with chronic illnesses, behavioral health conditions, physical disabilities or developmental disabilities.

(5) Supervisors of community integration service staff shall possess at least one of the following:

- (a) A current and valid license to practice in the state of Ohio as a registered nurse (RN), licensed practical nurse (LPN), licensed social worker (LSW) or licensed independent social worker (LISW);
- (b) A bachelor's degree or an associate's degree in human ecology, dietetics, counseling, gerontology, social work, nursing, public health, health education, or another related field; or
- (c) At least three years of employment experience providing community-based social services or job coaching.

(6) Supervisory responsibilities include:

- (a) Collaborating with the individual to identify, develop and document a specific activities plan, including the type of intervention(s) provided, prior to initiation of services that is consistent with the individual's approved person-centered services plan.
- (b) Conducting evaluations of community integration service staff every ninety days to ensure staff compliance with the activities plan, and the individual's satisfaction.

(E) All providers shall maintain a record at their place of business for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code for an ODM-administered waiver program, or with the requirements set forth in Chapter 173-39 of the Administrative Code for the PASSPORT program. The record shall include:

- (1) The individual's name;
- (2) A copy of the individual's initial and subsequent person-centered services plans;
- (3) A copy of the individual's approved activity plan;
- (4) Date(s) of service;

(5) A detailed description of each task or activity performed and the staff person who performed it; and

(6) The individual's signature to verify receipt of the service.

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Five Year Review (FYR) Dates:

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Certification

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Date

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5160-44-26

**Nursing facility-based level of care home and community-based services programs: community transition services.**

(A) "Community transition services" pay for non-recurring start-up living expenses for individuals transitioning from an institutional setting to a home and community-based services (HCBS) setting that is compliant with rule 5160-44-01 of the Administrative Code. Community transition services:

(1) Include expenses necessary to enable an individual to establish a basic household. Examples include:

- (a) Security deposits and rental expenses required to obtain a residential lease;
- (b) Basic household items required to occupy and maintain housing, including window coverings, food preparation items and linens;
- (c) Fees or deposits for utility or service access, including telephone/cellphone, electricity, gas, garbage and water;
- (d) Moving expenses;
- (e) Pre-transition transportation necessary to secure housing and benefits, etc.;
- (f) Initial grocery purchase, including food, cleaning supplies and household supplies;
- (g) Activities to arrange for and to procure other non-recurring set-up expenses; and
- (h) The provider's administrative costs associated with providing community transition services under this rule. Such fees shall be included in the authorization described in paragraph (A)(2)(b) of this rule.

(2) Are payable only to the extent:

- (a) They are determined reasonable and necessary through the person-centered services planning process described in rule 5160-44-02 of the Administrative Code and are clearly identified in an individual's person-centered services plan; and
- (b) They are authorized by the Ohio department of medicaid (ODM), the Ohio department of aging (ODA) or their designee in an individual's

person-centered services plan, which shall only occur if no other person, including a landlord, has a legal or contractual responsibility to fund the expense, and if family, neighbors, friends or community resources are unavailable to fund the expense.

(3) May be authorized up to one hundred and eighty consecutive days before an individual's transition from an institutional setting into an HCBS setting. The date of service for purposes of payment shall be the date the individual leaves the institutional setting. If the individual fails to transition to an HCBS setting, the service is still payable if all other requirements are met.

(4) Shall be provided no later than thirty days after the date on which an individual enrolls on a waiver.

(B) Community transition services do not include:

(1) Room and board, ongoing monthly rental or mortgage expenses;

(2) Ongoing grocery expenses;

(3) Ongoing utility or service expenses;

(4) Ongoing cable or internet expenses;

(5) Electronic and other household appliances or items intended to be used for entertainment or recreational purposes; and

(6) Tobacco products and alcohol.

(C) Limitations.

(1) Community transition services shall only be used one time per individual per waiver enrollment.

(2) Community transition services shall not exceed two thousand dollars per individual per waiver enrollment.

(D) The provider shall involve the individual and/or caregiver(s) in the selection of items to be purchased on the individual's behalf.

(E) Providers shall:

(1) Be either:

(a) An ODM-approved or ODA-certified waiver agency provider;

- (b) An ODM-approved or ODA-certified non-agency provider;
    - (c) A transition coordination service provider under contract with ODM that also meets the requirements set forth in paragraph (E)(1) of this rule; or
    - (d) An ODA-certified assisted living waiver service provider.
  - (2) Comply with the requirements set forth in rule 5160-44-31 of the Administrative Code for an ODM-administered waiver program, or Chapter 173-39 of the Administrative Code for the PASSPORT or assisted living programs.
- (F) All providers shall maintain a record at their place of business for each individual served in accordance with the requirements set forth in rule 5160-44-31 of the Administrative Code, or with the requirements set forth in Chapter 173-39 of the Administrative Code for the PASSPORT program. For each service provided, the record shall include:
  - (1) The individual's name;
  - (2) Date of service;
  - (3) A detailed description of each expense;
  - (4) A receipt for each expense;
  - (5) Verification the individual was involved in the selection of all items; and
  - (6) The individual's signature to verify receipt of the service.

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5160-46-04

**Ohio home care waiver: definitions of the covered services and provider requirements and specifications.**

This rule sets forth definitions of some services covered by the Ohio home care waiver. This rule also sets forth the provider requirements and specifications for the delivery of those Ohio home care waiver services. The services are reimbursed in accordance with rule 5160-46-06 of the Administrative Code.

**(A) Personal care aide services.**

(1) "Personal care aide services" are defined as services provided pursuant to the person-centered services plan that assist the individual with activities of daily living (ADL) and instrumental activities of daily living (IADL) needs. If the individual's person-centered services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. If the provider cannot perform IADLs, the provider shall notify ODM or its designee, in writing, of the service limitations before inclusion on the individual's person-centered services plan. Personal care aide services include:

- (a) Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;
- (b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, washing floors and waste disposal;
- ~~(c) Household chores, including but not limited to washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items to provide safe access and exit;~~
- ~~(d)~~(c) Paying bills and assisting with personal correspondence as directed by the individual; and
- ~~(e)~~(d) Accompanying or transporting the individual to Ohio home care waiver services, medical appointments, other community services, or running errands on behalf of that individual.

(2) Personal care aide services do not include tasks performed, or services provided as part of the home maintenance and chore services set forth in rule 5160-44-12 of the Administrative Code.

~~(2)~~(3) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the person-centered services plan.

~~(3)~~(4) Personal care aides shall not administer prescribed or over-the-counter medications to the individual, but may, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph (C) of rule 4723-13-02 of the Administrative Code, help the individual self-administer medications by:

- (a) Reminding the individual when to take the medication, and observing to ensure the individual follows the directions on the container;
- (b) Assisting the individual by taking the medication in its container from where it is stored and handing the container to the individual;
- (c) Opening the container for an individual who is physically unable to open the container;
- (d) Assisting an individual who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and
- (e) Assisting an individual who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the individual.

~~(4)~~(5) Personal care aide services shall be delivered by one of the following:

- (a) An employee of a medicare-certified, or otherwise-accredited home health agency; or
- (b) A non-agency personal care aide.

~~(5)~~(6) In order to be a provider and submit a claim for reimbursement, all personal care aide service providers shall meet the following:

- (a) Comply with all applicable rules set forth in Chapters 5160-44, 5160-45 and 5160-46 of the Administrative Code.
- (b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.
- (c) Be at least eighteen years of age.

- (d) Be identified as the provider, and have specified, on the individual's person-centered services plan that is prior-approved by ODM or its designee, the number of hours for which the provider is authorized to furnish personal care aide services to the individual.
  - (e) Have a valid social security number, and one of the following forms of identification:
    - (i) Alien identification,
    - (ii) State of Ohio identification,
    - (iii) A valid driver's license, or
    - (iv) Other government-issued photo identification.
  - (f) Not be the individual's legally responsible family member as that term is defined in rule 5160-45-01 of the Administrative Code.
  - (g) Not be the foster caregiver of the individual.
  - (h) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit.
  - (i) Comply with the additional applicable provider-specific requirements as specified in paragraph (A)(~~67~~) or (A)(~~78~~) of this rule.
- ~~(6)(7)~~ Medicare-certified and otherwise-accredited agencies shall ensure that personal care aides meet the following requirements:
- (a) Before commencing service delivery, the personal care aide shall:
    - (i) Obtain a certificate of completion of either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.36 (as in effect on October 1, 2018), and
    - (ii) Obtain and maintain first aid certification from a program that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.

- (b) Maintain evidence of the completion of twelve hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education shall be initiated immediately, and shall be completed annually thereafter.
  - (c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, shall:
    - (i) Conduct a face-to-face individual home visit explaining the expected activities of the personal care aide, and identifying the individual's personal care aide services to be provided.
    - (ii) Conduct a face-to-face individual home visit at least every sixty days while the personal care aide is present and providing care to evaluate the provision of personal care aide services, and the individual's satisfaction with care delivery and personal care aide performance. The visit shall be documented in the individual's record.
    - (iii) Discuss the evaluation of personal care aide services with the case manager.
  - (d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.
  - (e) Be able to effectively communicate with the individual.
- ~~(7)~~(8) Non-agency personal care aides shall meet the following requirements:
- (a) Before commencing service delivery personal care aides shall have:
    - (i) Obtained a certificate of completion within the last twenty-four months for either a competency evaluation program or training and competency evaluation program approved or conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 42 C.F.R. 484.36 (as in effect on October 1, 2018); or other equivalent training program. The program shall include training in the following areas:
      - (a) Personal care aide services as defined in paragraph (A)(1) of this rule;

- (b) Basic home safety; and
  - (c) Universal precautions for the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.
- (ii) Obtained and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.
- (b) Complete twelve hours of in-service continuing education annually that shall occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to, health and welfare of the individual, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.
  - (c) Comply with the individual's or the individual's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the individual or the case manager.
  - (d) Comply with ODM monitoring requirements in accordance with rule 5160-45-06 of the Administrative Code.
  - (e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.
  - (f) Be able to effectively communicate with the individual.
- ~~(8)~~(9) All personal care aide providers shall maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited agencies, shall maintain the clinical records at their place of business. Non-agency personal care aides shall maintain the clinical records at their place of business, and maintain a copy in the individual's residence. For the purposes of this rule, the place of business shall be a location other than the individual's residence. At a minimum, the clinical record shall contain:

- (a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers of the individual.
- (b) The medical history of the individual.
- (c) The name of individual's treating physician.
- (d) A copy of the initial and all subsequent person-centered services plans.
- (e) Documentation of all drug and food interactions, allergies and dietary restrictions.
- (f) A copy of any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.
- (g) Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and individual or the individual's authorized representative, verifying the service delivery upon completion of service delivery. The individual or the individual's authorized representative's signature of choice shall be documented on the individual's person-centered services plan, and shall include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.
- (h) Progress notes signed and dated by the personal care aide, documenting all communications with the case manager, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the individual.
- (i) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the individual, or when the individual no longer needs personal care aide services. The summary should include documentation regarding progress made toward achievement of goals as specified on the individual's all services plan and indicate any recommended follow-ups or referrals.

(B) Adult day health center services.

- (1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to individuals who are age eighteen or older. A qualifying adult day health center must be a freestanding building or a

space within another building that shall not be used for other purposes during the provision of ADHCS.

(a) An adult day health center shall provide:

- (i) Waiver nursing services as set forth in rule 5160-44-22 of the Administrative Code, or personal care aide services as set forth in paragraph (A)(1) of this rule;
- (ii) Recreational and educational activities; and
- (iii) At least one meal, but no more than two meals, per day that meet the individual's dietary requirements.

(b) An adult day health center may also provide:

- (i) Skilled therapy services as set forth in rule 5160-12-01 of the Administrative Code; and
- (ii) Transportation of the individual to and from ADHCS.

(c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to an individual in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided in a day.

(d) All of the services set forth in paragraphs (B)(1)(a) and (B)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.

(2) ADHCS do not include services performed in excess of what is approved pursuant to, and specified on, the individual's person-centered services plan.

(3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS shall:

- (a) Comply with all applicable rules set forth in Chapters 5160-44, 5160-45 and 5160-46 of the Administrative Code.
- (b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.
- (c) Be identified as the provider on the individual's person-centered services plan, that is prior-approved by ODM or its designee, the number of hours

for which the provider is authorized to furnish adult day health center services to the individual.

- (d) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.

(4) All providers of ADHCS shall:

- (a) Comply with federal nondiscrimination regulations as set forth in 45 C.F.R. part 80 (as in effect on October 1, 2018).
- (b) Provide for replacement coverage of a loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps an individual takes to file a liability claim. Upon request, verification of coverage shall be provided to ODM or its designee.
- (c) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training every twelve months.
- (d) Ensure that any waiver nursing services provided are within the nurse's scope of practice as set forth in rule 5160-44-22 of the Administrative Code.
- (e) Provide task-based instruction to direct care staff providing personal care aide services as set forth in paragraph (A)(1) of this rule.
- (f) At all times, maintain a 1:6 ratio of paid direct care staff to individuals.

(5) Providers of ADHCS shall maintain a clinical record for each individual served in a manner that protects the confidentiality of these records. At a minimum, the clinical record shall contain the following:

- (a) Identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.
- (b) The medical history of the individual.
- (c) The name of the individual's treating physician.
- (d) A copy of the initial and all subsequent all services plans.
- (e) A copy of any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.

- (f) Documentation of all drug and food interactions, allergies and dietary restrictions.
- (g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the individual's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- (h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ADHCS provider is no longer going to provide services to the individual, or when the individual no longer needs ADHCS. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.
- (i) Documentation of the information set forth in rule 5160-44-22 of the Administrative Code when the individual is provided waiver nursing and/or skilled therapy services.

(C) Supplemental adaptive and assistive device services.

- (1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that are suitable to enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. All supplemental adaptive and assistive device services shall be prior-approved by ODM or its designee. ODM or its designee shall only approve the lowest cost alternative that meets the individual's needs as determined during the assessment process.
  - (a) Reimbursement for medical equipment, supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a calendar year per individual.
  - (b) ODM or its designee shall not approve the same type of medical equipment, supplies and devices for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.

(c) ODM or its designee shall not approve the same type of vehicle modification for the same individual within the same three-year period, unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.

(d) Supplemental adaptive and assistive device services do not include:

- (i) Items considered by the federal food and drug administration as experimental or investigational;
- (ii) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;
- (iii) Equipment, supplies or services furnished in excess of what is approved in the individual's person-centered services plan;
- (iv) Replacement equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of perceived misuse, abuse or negligence; and
- (v) Activities described in paragraph (C)(2)(c) of this rule.

(2) Vehicle modifications.

- (a) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same individual. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.
- (b) Before the authorization of a vehicle modification, the individual and, if applicable, any other person(s) who will operate the vehicle shall provide ODM or its designee with documentation of:
  - (i) A valid driver's license, with appropriate restrictions, and if requested, evidence of the successful completion of driver training from a qualified driver rehabilitation specialist, or a written statement from a qualified driver rehabilitation specialist attesting to the driving ability and competency of the individual and/or other person(s) operating the vehicle;

- (ii) Proof of ownership of the vehicle to be modified;
- (iii) Vehicle owner's collision and liability insurance for the vehicle being modified; and
- (iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

(c) Vehicle modifications do not include:

- (i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (C)(2)(a) of this rule;
- (ii) Routine care and maintenance of vehicle modifications and devices;
- (iii) Permanent modification of leased vehicles;
- (iv) Vehicle inspection costs;
- (v) Vehicle insurance costs;
- (vi) New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and
- (vii) Services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.

(3) In order to be a provider and submit a claim for supplemental adaptive and assistive device services, the provider shall:

- (a) Comply with all applicable rules set forth in Chapters 5160-44, 5160-45 and 5160-46 of the Administrative Code.
- (b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.
- (c) Be identified as the provider, and have specified, on the individual's all services plan that is prior-approved by ODM or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the individual.
- (d) Ensure all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services.

- (e) Ensure the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.
- (4) Providers of supplemental adaptive and assistive device services shall maintain a clinical record for each individual they serve in a manner that protects the confidentiality of these records. At a minimum, the clinical record shall include:
- (a) Identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers of the individual.
  - (b) The name of the individual's treating physician.
  - (c) A copy of the initial and all subsequent person-centered services plans.
  - (d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- (D) Supplemental transportation services.
- (1) "Supplemental transportation services" are transportation services that are not available through any other resource that enable an individual to access waiver services and other community resources specified on the individual's person-centered services plan. Supplemental transportation services include, but are not limited to assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.
  - (2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's all services plan.
  - (3) In order to be a provider and submit a claim for supplemental transportation services, the provider shall:
    - (a) Comply with all applicable rules set forth in Chapters 5160-45 and 5160-46 of the Administrative Code.
    - (b) Request reimbursement for the provision of services in accordance with rule 5160-46-06 of the Administrative Code.

- (c) Be identified as the provider, and have specified on the individual's person-centered services plan that is prior-approved by ODM or its designee, the amount of supplemental transportation services the provider is authorized to render to the individual.

(4) Agency supplemental transportation service providers shall:

- (a) Maintain a current list of drivers.
- (b) Ensure all drivers providing supplemental transportation services are age eighteen or older.
- (c) Maintain a copy of the valid driver's license for each driver.
- (d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services.
- (e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.
- (f) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services that:
  - (i) Is not provided solely through the internet;
  - (ii) Includes hands-on training provided by a certified first aid instructor; and
  - (iii) Requires the individual to perform a successful return demonstration of what was learned in the course.
- (g) Ensure drivers are not the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.
- (h) Ensure drivers are not the individual's foster caregivers.

(5) Non-agency supplemental transportation service providers shall:

- (a) Be age eighteen or older.
- (b) Possess a valid driver's license.
- (c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services.

- (d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services.
  - (e) Obtain and maintain a certificate of completion of a course in first aid that:
    - (i) Is not provided solely through the internet;
    - (ii) Includes hands-on training provided by a certified first aid instructor; and
    - (iii) Requires the individual to perform a successful return demonstration of what was learned in the course.
  - (f) Not be the individual's legally responsible family member, as that term is defined in rule 5160-45-01 of the Administrative Code.
  - (g) Not be the individual's foster caregiver.
- (6) All supplemental transportation service providers shall maintain documentation that, at a minimum, includes a log identifying the individual transported, the date of service, pick-up point, destination point, mileage for each trip, and the signature of the individual receiving supplemental transportation services, or the individual's authorized representative. The individual's or authorized representative's signature of choice shall be documented on the individual's person-centered services plan and shall include any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

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10/25/2010, 07/01/2015, 11/03/2016, 01/01/2019

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) "Bid rate," as used in table B, column 3 of paragraph (B) of this rule, means the per job bid rate negotiated between the provider and the individual's case manager.

~~(2)~~(3) "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)~~(4) "Caretaker relative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

~~(4)~~(5) "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)~~(6) "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 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 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)~~(7) "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)~~(8) "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, 2018).

~~(8)~~(9) "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)~~(10) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount reimbursed by 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. 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	Personal emergency response systems	Per installation and testing	\$32.95
S5161	Personal emergency response systems	Per monthly fee	\$32.95
S5165	Home modification services	Per item	Amount prior-authorized on the <del>all</del> <u>person-centered</u> services plan, <u>not to exceed \$10,000 in a twelve-month calendar year</u>
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the <del>all</del> <u>person-centered</u> services plan, <u>not to exceed \$10,000 in a twelve-month calendar year</u>
S5170	Home delivered meal services - standard meal	Per meal	\$6.50
S5170	Home delivered meal services - therapeutic or kosher meal	Per meal	\$8.68
<u>S5135</u>	<u>Community integration services</u>	<u>Per fifteen-minute unit</u>	<u>\$3.50</u>

<u>T2038</u>	<u>Community transition services</u>	<u>Per job</u>	<u>\$2,000</u> <u>per waiver</u> <u>enrollment</u>
<u>S5121</u>	<u>Home maintenance and chore services</u>	<u>Per job</u>	<u>Amount prior-</u> <u>authorized on</u> <u>the person-</u> <u>centered</u> <u>services plan,</u> <u>not to exceed</u> <u>\$10,000 in a</u> <u>twelve-month</u> <u>calendar year</u>

(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.

Effective:

Five Year Review (FYR) Dates: 1/1/2022

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Certification

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Date

Promulgated Under: 119.03

Statutory Authority: 5162.03, 5166.02

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5166.041

Prior Effective Dates: 01/01/2004, 07/01/2006, 07/01/2008, 01/01/2010,  
04/01/2011, 10/01/2011, 07/01/2015, 01/01/2017,  
01/01/2019

5160-58-04

**MyCare Ohio waiver: covered services and providers.**

- (A) The purpose of this rule is to establish both the services covered by the MyCare Ohio home and community based services (HCBS) waiver program and the providers eligible to furnish those services to members enrolled in the MyCare Ohio waiver.
- (B) Providers seeking to furnish services in the MyCare Ohio waiver program shall meet the requirements in Chapter 173-39, 5160-45 or 5160-44 of the Administrative Code, as appropriate. Prior to furnishing services to MyCare Ohio waiver recipients, the services must be documented on the member's person-centered services plan as described in rule 5160-44-02 of the Administrative Code.
- (C) MyCare Ohio waiver covered services are limited to the following and exclude any reimbursement provisions in the Ohio Administrative Code rules cited therein:
- (1) Adult day health services as set forth in rule 173-39-02.1 or 5160-46-04 of the Administrative Code;
  - (2) Alternative meal services as set forth in rule 173-39-02.2 of the Administrative Code;
  - (3) Assisted living services as set forth in rule 173-39-02.16 of the Administrative Code;
  - (4) Choices home care attendant services as set forth in rule 173-39-02.4 of the Administrative Code;
  - ~~(5) Chore services as set forth in rule 173-39-02.5 of the Administrative Code;~~
  - (5) Community integration services as set forth in rule 173-39-02.15 or 5160-44-14 of the Administrative Code;
  - (6) Community transition services as set forth in rule 173-39-02.17 or 5160-44-26 of the Administrative Code;
  - (7) Enhanced community living services as set forth in rule 173-39-02.20 of the Administrative Code.
  - (8) Homemaker services as set forth in rule 173-39-02.8 of the Administrative Code;
  - (9) Home care attendant services as set forth in rule 173-39-02.24 or 5160-44-27 of the Administrative Code;

- (10) Home delivered meal services as set forth in rule 173-39-02.14 or 5160-44-11 of the Administrative Code;
  - (11) Home maintenance and chore services as set forth in rule 173-39-02.5 or 5160-44-12 of the Administrative Code.
  - ~~(H)(12)~~ (12) Home medical equipment and supplemental adaptive and assistive devices services as set forth in rule 173-39-02.7 or 5160-46-04 of the Administrative Code;
  - ~~(H)(13)~~ (13) Home modification services as set forth in rule 173-39-02.9 or 5160-44-13 of the Administrative Code;
  - ~~(13) Independent living assistance services as set forth in rule 173-39-02.15 of the Administrative Code;~~
  - (14) Nutrition consultation services as set forth in rule 173-39-02.10 of the Administrative Code;
  - (15) Out-of- home respite services as set forth in rule 173-39-02.23 or 5160-44-17 of the Administrative Code;
  - (16) Personal care aide services as set forth in rule 173-39-02.11 or 5160-46-04 of the Administrative Code;
  - (17) Personal emergency response services as set forth in rule 173-39-02.6 or 5160-44-16 of the Administrative Code;
  - (18) Pest control services as set forth in rule 173-39-02.3 of the Administrative Code;
  - (19) Social work counseling services as set forth in rule 173-39-02.12 of the Administrative Code;
  - (20) Waiver nursing services as set forth in rule 173-39-02.22 or 5160-44-22 of the Administrative Code; and
  - (21) Waiver transportation services as set forth in rules 173-39-02.13 and 173-39-02.18 or 5160-46-04 of the Administrative Code.
- (D) If a member enrolled in the MyCare Ohio waiver is also a participant in the helping ohioans move, expanding (HOME) choice demonstration program pursuant to Chapter 5160-51 of the Administrative Code, the member may use the HOME choice community transitions service in lieu of, but not in addition to, the community transition service available through the MyCare Ohio waiver.

- (E) If a member receives enhanced community living services, the member shall not also receive personal care or homemaker services available through the MyCare Ohio waiver.
- (F) The following services may be participant-directed using budget and/or employer authority. To exercise these authorities, members must demonstrate the ability to direct providers in accordance with paragraph (D) of rule 5160-58-03.2 of the Administrative Code:
- (1) Employer authority which includes, but is not limited to, the ability of the member to hire, fire, and train employees is available for the following services:
    - (a) Choices home care attendant services provided by a participant-directed individual provider; and
    - (b) Personal care services provided by a participant-directed personal care provider.
  - (2) Budget authority which includes the ability of the member to negotiate rates of reimbursement is available in the following services:
    - (a) Alternative meals;
    - (b) Choices home care attendant services;
    - (c) Home maintenance and chore services;
    - ~~(e)(d)~~ Home modification, maintenance and repair, services; and
    - ~~(d)~~ Pest control; and
    - (e) Home medical equipment and supplemental adaptive and assistive devices.

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Certification

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